Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>012</u> Physician/ Francis William Sherman October=9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 611 Deale Road Deale Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days 030-18-5500 Director 1 X M 2 - F 85 July 11, 1927 Massachusetts Usual Residence of Deceden filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20751 United States 611 Deale Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. 1942-53 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ð 1 Never Married 2 M Married Maryland 21215-0036 1 Yes 2 No 3 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Marina & Tour Bus Business Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event SIME8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Pollard Francis George Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 2921 Leisure World Blvd., Silver Spring, MD 20906 Elizabeth E. Sherman/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cenetery 10/12/2012 Silver Spring, MD 21. Signature of Funeral Services 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater. MD 2103 Part 1 Enter the disease, or complications that causeus sheek, or heart failure. List only one cause on each line. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Melaste Bone Medical Due to (or as a consequence of) ears Examiner o wa cinom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and shed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Yes 2 □ No To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it q ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cascinema 7 Soph 1 🗌 Yes 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate performi death? 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 잂 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 124 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -10-2012 0019421 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 HOSP RD. Prince Frederick MD 20678 MUNSHI.M.D Simle 300. 31. Date filed (Month, Day, Year) State 11 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dolly Mae Smith 2:10 P.M 2012 Medical October 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick **Examiner** 4b. City, Town, or Location of Death Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 214-34-0937 Director 76 1 □ M 🗶 □ F June 30,1936 Maryland Usual Residence of Dece 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Md. Frederick Frederick 1) Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 274 Pinoak Lane 21701 U.S.A items ner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or i edical Examin Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha College (1-4 or 5+) President Carpet Co. traumatic event, Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Atlee Kinna Gladys Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Smith (Husband) 274 Pinoak Lane Frederick, Md. 21701 other Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. injury or Department Important: If any injury or once. Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave M01414 J.L. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MYLOFIBROSCARCOL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or in that initiated events attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Day 5 Other (specify) Month Year 1 Yes 2 9 Unknown detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s performe certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🗷 No Other: Kline Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death Il Director: After the 28b. Time of House Certificate: 28c. Injury at work? 28d. Describe how injury occurred 2 Accident
3 Suicide 1 🗹 Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 10/15/12 0 R069310 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Crum-Múehl N.P. 1564 Opossumtown Pike Frederick, Md. 21702

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 35003 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Patrick Henry Topps October 9 рм 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3901 Cleveland Street Kensington Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 081-01-0567 (Month, Day, Year) Director 1 🖾 M 2 🗆 F 93 Nov. 10, 1918 NY Usual Residence of Decedent in then "neturel", or Items 23e or 28e-f ehow the Medical Examiner must be notified at fled within 72 hours efter death with the Merylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Kensington Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3901 Cleveland Street 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ₹ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Porter it. Pege 1 end 2 should be filed with thrent of Heelth end Mentel Hygler trant: If Item 27 is merked other 1 njury or other treumetic event, the streem of t Railroad Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Topps, Sr. May Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Topps/Daughter 3901 Cleveland Street, Kensington, MD 20895 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 IC Cremation 3 ☐ Removal from State cemetery, crematory or other place) permit. Pege Depertment of Important: If eny Injury or Oct. 4 ☐ Donation 5 ☐ Other (Specify) letropolitan Crematory 2012Alexandria, VA 21. Signature of Funeral Service Densee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or conditi-resulting in death) a. Chronic Renal Disease 1 Medical Due to (or as a consequence of) Examiner _b Diabetes 10_yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Exami bege 2 should be detached for use as the burial-transit. To the Hoepitel or Attending Physicien: The lew requires that the deeth certificete be executed Chronic Ischemic Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours efter death.

To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2. autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🖾 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work*:* 1 ☐ Yes 2 ☐ No 2 Accident Investigation M ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) MD8990 October 10, 2012 of person who completed Chester, MD ursé of death (Item 23a) (Type, Print) 3301 New Mexico Ave., NW, Washington, DC 20016 ath (Item 23a) (Type, Print) Alexander 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 Registrar OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yrone Taylor		- For State	ate of Maryla		artment of rtificate of i		Mental H		20 Reg. No.	12 3500	
Physiciar Medical Examin	1/	Registrar 1. Decedent's Name (First, Midd Tyrone Marqui			F			2. Date of Dea Month October 2	ath	3. Time of Death 0420 hrs	
		4a. Facility Name (if not institution Holy Cross Hospital	on, give street and nu	mber)	1	City, Town, or L Silver Spring			4c. County of D Montgome		
Funeral Director		5. Social Security Number 578-11-0828	6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	1.		Birthplace (State or preign Country) ashington, DC	
nd Sthow any	Ī	Usual Residence of Decedent 10a. State 10b. County MD Mo	ntgomery	10c. City	, Town or Location					10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 14310 01d Co1		e		10f. Zip Code	866		10g. Citizen of What	Country?	
er death wi	Funeral	11. Marital Status 1 Never Married 2 MM 3 Widowed 4 Div		2 X No	If Yes	Decedent of Hispa , specify Cuban, I	anic Origin? (S		o- 14. Race - A White, e	merican Indian, Black,	
16 n 72 hours aft san "natural" ical Examine	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grad	le completed)	16a. Decedent's during mos	Usual Occupatio t of working life. I	n (Give kind of DO NOT use ret		16b. Kind of Busine	ess/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: Witem 27 is marked other than Injury or other transmittic event, the Medical Committee of the Property of the Committee of the Medical Committee of the Committee of the Medical Committee of the Committee	De Com	17. Father's Name (First, Middle, Calvin Fergus					3.Mother's Name Wanda	Taylor			
MD 21 nd 2 should alth and Mes ma 27 is ma raumatic cv	_[19a. Informant's Name/Relations Christie Taylo 20a. Method of Disposition		20h		Tuckahoe	Lane,		mber, City or Town, Soville, MD 20c. Location - Cit	20783	
Baltimore, Demit. Pages I at Department of He Important: If ite		Burial 2 X Cremation Donation 5 Other Sp. Signature of Funeral Service	pecify:	om State	crematory or othe ropolita	rplace) n Cremat	ory Oc	t. 28, 2012	Alexandr	ia, VA	
Physician	ļ	23a. Part Venter the disease, or failure. List only one cause	complications that ca	aused the death	, 500	Univers	ity Blv	d. W.,	al Home In Silver Sp rest, shock, or heart	c ring, MD 20901 Approximate Interval Between Onset and	
/Medical Examiner	İ	Immediate Cause (Final disease or condition resulting in death)				scular D	isease			Death	
6		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c. Due to (or as a								
be execuician and	<u> </u>	X UNPENDED	d AMENDED 2	.3a,pt.]	II,27,pe	me,g93	3 11-5-	12 sm			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-translation of the contraction of th		IF FEMALE: (3b. Was decedent pregnant in the past 12 months?) 1 Yes 2 No 9 Unit	1 Live bi	ant at time of de	2 Fetal	death 3	Ectopic pregna	ancy	23d. Date of del Month	very Day Year	
P.O. Be ires that the designed by the be detached if		Part II. Other significant condit	•	ntributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 W Unknown		
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Physician: The rhis certificate al director, page		25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 In		ER/Outpatient	DOA O	-	ng Home 5		ther.	
Division of and or Attending Phesa after death. al Director: After 1 led in by the funeral led in by the funeral attention.	erification:	27. Manner of Death 1 X Natural 5 Penc 2 Accident Inves	ding stigation	Day, Year)	28b. Time of Inju	1 Ye	s 2 No		how injury occurred		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	`> ⊨		d not be rmined 28e. Place (Specify)	of Injury - At h	ome, farm, street,	factory, office bui	lding, etc.	28f. Location (or Town, S		r Rural Route Number, City	
Ditte Hospital To the Funeral completely filled		(Check only one) 2 Medical Exa	miner: On the basis of and manner st	f examination a		n, in my opinion, o	leath occurred a		se(s) and manner as and place, and due t	o the cause(s)	
3 few	2	29b. Signature and title of certifie				29c. License : O.C.M			29d. Date signed October 21, 2	•	
		30. Name and address of person Ana Rubio M.D., Ph. [D. Assistant N	ledical Exa	miner 900 V	V. Baltimore \$	Street, Baltir	more, MD 2	1223		
Stat Registra	_	31. Date filed (Month, Day, Year)		gistrar's Signatu	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day/ 10 1617 Virginia Tull Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburi Wicomico Peninsula Regional Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 213-14-6960 1 ☐ M 2 ☐XF 96 4-15-1916 VA Usual Residence of Decedent permit. Pege 1 and 2 should be flied within 72 hours efter death with the Meryland Department of Heelth and Mentel Hygiene. Important: If itsm 27 is merked other then "natural", or items 23e or 28e-f show sur injury or other treumetic event, the Medical Evaniner must be notified at once. 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2X No Worcester <u>Pocomoke</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Laurel Street 21851 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Spe Bylack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Farming Industry <u>Laborer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>Smith Jones</u> Sue Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Elenore Wise/Daughter</u> 614 Clark Ave, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Hope Bapt Cem 10-13-2012 Stockton, MD Signature of Enneral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capte on each line. Immediate Cause (Final Onset and Death Physician 1 remanenta disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury Examine Due to (or as a consequence of): To the Hospital or Attanding Physicien: The lew requires that the deeth certificate be executed within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes No 1 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 8 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) nd title of gertifier 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) 163199 10/5 112, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

DR, SALISBURY, MD, 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Mary					201	2 35006
			Registrar	Cer	tificate of L	Jeath		Reg. No. 🚄 🔱 🚶	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		ear
	Medic	al .	McKinley Tyler 4a. Facility Name (if not institution, give street and number)		4b City Town o	r Location of Death	10	4c. County of	
	Examin	er	Clinton Nursing & Rehab. Cer	ntor	Clint			1	e Georges
200	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9	J. Birthplace (State or Foreign
	Director		251-64-1909 1 [™] M2□F	Yrs.	Months Days	Hours Min.	(Month, Day	11000	Country)
	D wo		Usual Residence of Decedent 10a, State 10b, County 10	83 lc. City, Town or Lo	cation		09/00/	1727	South Carolina 10d. Inside City Limits
	ırylan I-f sh ied a	cto				. 1 .			1 🏝 Yes 2 □ No
	or 282 notif	Director	MD Prince Georges 10e. Street and Number	D18	strict He	eignts		10g. Citizen of Wha	at Country?
	with th	iral	2009 Brewton Street		207	47		USA	
	eath v	Funeral	11 Marital Status 12. Was Decedent Ever	in U.S. 13.	Vas Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,
ဖွ	ter de , or it	by	1 □ Never Married 2 ☑ Married Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give 196	2_68	f Yes, specify Cuba □ Yes 2 🎦 No		o nicari, etc.)	Specify	White, etc.
8	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at the Medical Examiner for the state of the st	Completed	3 - Widowed 4 - Divorced Year or Dates.						Black
7	72 ho "na'r ledic	l ple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done (O NOT use retired)	during most of wor	rking	16b. Kind of Busir	iess/Industry
77	rithin iene.	Sol	Elementary/Secondary (0-12) College (1-4 or 5+)		ial Polic		r	Federal (Government
b	be filed wental Hyg ked othe ic event,		17. Father's Name (First, Middle, Last)					Maiden Sumame)	
/lar	d be f Jenta arked tic ev	유	Harvester Tyler			Galati	a Gloste	er	
lan	should and b is ma		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, Stat	
≥ ′	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Francine Tyler/ Spouse			Street			, MD 20747
Baltimore, Maryland 21215-0036	ge 1 g nt of H : If ite or ot		1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	natory or other pla	i	Date	20c. Location - Ci	
Εij	iit. Pa		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	MD Veter					am, Maryland 1 Home, Inc.
\mathbf{B}_{a}	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once.	11	Sour Mortsomers Cheat					entwood,	
		Н	23a. Part 1. Inter the disease or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
١,	Plu i ian/		Immediate Cause (Final disease or condition	neteco	A				Onset and Death
	Medical		resulting in death) a. Due to (or as a co	onsequence of):	11				
	Examiner	<u>_</u>	Sequentially list conditions, b.	SRD.	-HD				
	d sit	nine	if any, leading to immediate Due to (or as a co	onsequence of):					
	ecute and I-trans	xar	Cause (Disease or injury that initiated events c. Due to (or as a co	onsequence of):					
_	ate be executed obysician and the burial-transit	dical Examine							
092	icate p phys	ledi	0.						
289	certif anding use a	N/ne	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 [oregnancy	Ectonic pregnan	ICV		23d. Date	
Вох	death ie atte ed for	sicia	1 Yes 2 No		Other (specify)			Month	n Day Year
P.O.	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	9 Unknown Part II. Other significant conditions contributing to death but r	not reculting in the	Inderlying cause a	iven in Port I	220 Did+	obacco use contribu	ute to the cause of death?
	es that igned be de	by	Part II. Other significant conditions contributing to death but i	lot resulting in the t	andenying cause g	Wolf if I dict.			☐ Probably 4 H Unknown
Records,	requires been sig should b	Completed					24a. Was		ere autopsy findings available
000	The law rate has be	m D					auto	psy prie ormed? dea	or to completion of cause of ath?
m	sician: The certificate irector, pag	ပိ	25. Was case referred to medical		26 P	Place of Death (Che		2 K No 1	Yes 2 No
/ita	sicial s certi	To Be	examiner?	2 ER/Outpatie	Ott	nor:		dence 6 Other	(Specify)
of/	g Phy er this neral o		27. Manner of Death 28a. Date of injury	28b. Time o		ry at		now injury occurred	
on	anding eath. or: Aft	ficat	2 Accident Investigation	ear) Injury		Yes 2 No			
Division of Vital	r Atter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (\$\(\)		reet, factory, office		28f. Location (City or Tox		or Rural Route Number,
Ö	Hospital or 24 hours afte Funeral Din etely filled in						and due to the o	auso(a) and manner	on stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practitioner: To the busis of examonly one)	nination and/or inves	stigation, in my opin	ion, death occurred	at the time, date	and place, and due to	o the cause(s) and manner stated
	To the within 2 To the comple	Σ	only one) 3 Certifying Nurse Practitioner: To the but 29b. Signature and title of certifier	cat of my knowledge	29c. Licens		prace, and decre	29d. Date signed (
	> - 0		Mich Clover	CRIMP	121.	5052	20	10/10/	12
	10+1 5M		30. Name and address of person who completed cause of deat	h (Item 23a) (Type,	Print)		^	- 1- 11	
	3		6434 Avietin Wood 5	Tel E	Slen B	urnic, i	ms -	21061	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	20 A	•			
	negisti	वा	4						

		1 - For State en Registrar	d / Depa		Health and	Mental Hy		35007
	ician dical	1. Decedent's Name (First, Middle, Last) Oscar Varnell Taylor			204	2. Date of De Month		3. Time of Death
Exar	niner —	8874 Chesapeake Lighthouse	Dr.	4b. City, Town, c	r Location of Dea Beach		4c. County of De Calver	ath
Funer Direct		5. Social Security Number 6. Sex 1 M 2 F 6. Sex 6. Sex 1 M 2 F 6. Sex 6.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			irthplace (State or Foreign Country)
Maryland a-f show	ctor	10a. State 10b. County 10c. City,	Nort	th Beacl	h			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
uth with the 23a or 28	Funeral Director	10e. Street and Number 8874 Chesapeake Lighthouse	Dr.	10f. Zip Code 20	714		10g. Citizen of What C	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Item Madical Examinations in the profiled at	d by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Wes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 3 □ Widowed 4 □ Divorced 1 □ Yes 3 □ Wear or Dates:		Was Decedent of H If Yes, specify Cub 1 □Yes 2 ☑ No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race - Arr Black, Wh Specify B1:	te, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or any injury or other traumatic event, in Medical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 1	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired 1Ck Driv	during most of wo d)	orking	16b. Kind of Business	•
aryland should be file and Mental Hy s marked othe	To Be C	17. Father's Name (First, Middle, Last)	r		18. Mother's Na Lillia		Maiden Surname) Booth	
e, Mar 1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Type. Print) Claudia Wilson-Taylor/wife 20a. Method of Disposition 20b. Pla	8874 North	∪nesape 1_Beach.	eake Li MD 20	ghthous 714	er, City or Town, State, e Drive	
ITIMOR nit. Pages artment of ortant: If it	aŭ.	1 DXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	1t. \	sition (Name of natory or other place) Tet. Cen	n. 10/	Date 16/2012		nham, MD
any any	OUC	Pladen a. Sewell 23a. Part 1. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause are sack line.	1 4	51 Dare	es Beac	well Fu h Rd. P	neral Hor rince Fre	ne, P.A. ed.MD 20678
Physicia /Medica	af .	Immediate Course (Final	Caric	ER.	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
f bU, te be executed ysician and e burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Extended the Jordan Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence) c. Due to (or as a consequence)						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d	leath 3 ath 5	Ectopic pregnanc			23d. Date of de Month	elivery Day Year
v requires the	Ş	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.		bacco use contribute t es 2 ☐ No 3 ☐ F	o the cause of death? robably 4X Unknown
an: The law tificate has b	e Completed	25. Was case referred to medical				24a. Was a autop perfor 1 □ Yes	sy prior to med? death? 2 ■ No 1 □ Ye:	utopsy findings available completion of cause of
ding Physician: The In. h. After this certificate har	n: To B	examiner? 1 Yes 2 No 1 Inpatient 2 EF 27. Manner of Death 28a. Date of Injury 28	R/Outpatient		er: 4 🗆 Nursing H		ne) ence 6 □Other (Spe ow injury occurred	ecify)
or Attendin fter death. irector: Aft n by the fun	Certification: To	15 ☐ Natural 5 ☐ Pending (Month, Day, Year) investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	Injury e, farm, stre		res 2 □ No		treet and Number or R	ural Route Number,
To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, death	occurred at the tin	ne, date and place	and due to the	()	s stated.
To the within To the comple	√ Mec	29b. Signature and title of certifier		29c. License			29d. Date signed (Moni	
KWI		30. Name and address of person who completed cause of death (Item 23		01 1	1524	-16	10/6/20	112
	tate trar	31. Date filed (Month, Day, Year) 32. Registrate Signature OCT - 97117) Annua	e A	Spares	ince tre	d mil	/	
HMH 17 Rev 1	/2001	Commo		19 avoi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PATRICIA ELAINE October 2012 0:15 TAMMINGA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick <u>Frederick</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months 366-72-1955 Director 1 □ M 2 🕱 F 55 June 19, 1957 Michigan Usual Residence of Deceder r then "netural", or iteme 23e or 28e-f ehow the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7933 Forest Stream Club Road 21757 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 M Married 2 Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 21X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 | h end Mental Hygiene. 7 Is merked other then "r Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Family Business other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Nichoson Velma Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health er Importent: If item 27 Is eny Injury or other treu Daniel W. Tamminga, Sr./Husband 7933 Forest Stream Club Rd. Keymar, MD 21757 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. Date 1 ☐ Burial 2 KX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2012 Frederick, Maryland 21. Signature of Funeral Service Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disconshoot, or heart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Imm te Cause (Fin Onset and Death Physician/ morrari disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physiclen and the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pege 2 has autopsy prior to death? performe 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical **Division of Vital** 8 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ည 1 Nanpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of certifie 29b. Signature and tit 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 hMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 9^{Pay} 2012^{eai} Leon H. Underwood 10:27 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6361 Claridge Drive North Frederick Frederick 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours 217-74-7368 Director 1 M 2 F Vre 48 Dec.1, 1963 Maryland Usual Residence of Decede show 10a. State the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sl must be notified 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6361 Claridge Drive North 21701 USA ral", or items 2 Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", Specify 3 Widowed 4 Divorced Completed White Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Manager Tire Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dewey Underwood Barbara Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Underwood / Wife 6361 Claridge Drive N., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Resthaven Memorial 10/13/2012 Frederick, Maryland Signatur of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Fart 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Month Day Year ed by the a Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by should be Hospital or Attending Physician: The law requires 1 Yes 2 10 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Numa Pranylianon To the cause(s) and manner as stated. (Check only or 29b. Signatur nd title of certifier 29d. Date signed (Month, Day, 11 12 gistrar's Signature State accord. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1-State Registra Amend #26 Per FH JM 10/1997 ifficate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 2012 October 09 3:10a [™] Sudie M. Vann Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's Aldephi House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** (Month, Day, Year) Director 245-50-5722 1 🗌 M 2 🖾 F 82 12-22-1929 Clinton, N.C. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 ☐ No Prince George's Lanham MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20706 1418 8th Street death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Nayamond Lamb Mary Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Vann / Daughter 1418 8th Street Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft.Lincoln Cemetery | 10-13-2012 | Brentwood, MD of Funeral Solvice 22. Name and Address of Facility Fort Lincoln Funeral Home B401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death -RO Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? be detached for Pregnant at time of death 1 ☐ Yes ∠ ₽ 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON'S 1 Yes 2 No 3 Probably 4 Unknown DISEASE page 2 should DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No HYPERTENSON 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 I DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending after death. Director: Af 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 0036091 10/10/2012 Jim 30. Name and address of person who completed cause of death (New 23a) (Type, Print)

ANTHONY BOAKYEMD 888 BESTGATE RD AWAAPOLIS MD 21401

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Joan Wrabe 8:29 AM Detob 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death George's Mospital Center Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 160-32-8361 **Director** 1 □ M 2 😿 F 73 8/01/1939 PA Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George' 1 Yes 2 No Upper Marlboro 10e, Street and Numbe 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r Funeral 11916 Wimbleton Street 20774 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Head Teller 12 Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Charles Valonis Sr. Julia Wnuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Paul J.Wrabel/husband 11916 Wimbleton St. Upper Marlboro, Md. 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2012 Cathedral Cem. Scranton, PA 21. Signatur PHILIPADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** pneumonia Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed D and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy hours after death. Ineral Director: After this certificate I 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 10, 2012 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stahl 3001 Hospital Dr Cheverly MD Kathryn

State

Registrar

31. Date filed (Month, Day, Year)

12

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oct.11 Hazel E. White .2012 7:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing & Rehab Walkersville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. 3/22/14918 121-12-8368 94 Director New York Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Walkersville MD 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 21793 USA 56 W.Frederick Street hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blanche Forrest Douglas White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6528 Nightengale Court New Market, Md. 21774 Dorlene Muhs/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 10/12/2012 Beltsville, Md. 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lic PHITTP AUSTRINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stroke Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Parist Parist Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy o in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy certificate Yes 21 No within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1X Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Saeed Zaidi 31. Date filed (Month, Day, Year) 0CT 15 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

801

Registrar's Signat

1 🔀 Certifying Physician: To the Dest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D430

29d. Date signed (Month. Dav. Year)

Oct.12,2012

Frederick, Md 21701

29c. License number

Tollhouse Ave Bldg.E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 12. Physician/ 201^{ear} 6:00 aM Lillian Virginia West Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner P.G. Renaissance Gardens at Riderwood Village Silver Spring Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 579-12-3630 1 □ M 2 🏝 F 93 Sept. 12, 1919 Washington, DC or 28a-f show a notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Silver Spring 1 Yes 2 X No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ō event, the Medical Examiner must be 23a Funeral with 3154 Gracefield Road, Apt. 317 20904 USA items , death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married ō ģ 1 Yes If Yes, Give filed within 72 hours after Specif White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other t Banker VP Bank of America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles O'Connor Lillian Virginia Mills injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra David West/Husband 3154 Gracefield Road, #317, Silver Spring,MD 20904 Date 17, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 2<u>017</u> Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Rock Creek Cemetery Washington, DC Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Pneumonia Medical Due to (or as a consequence of): Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter endenying Examine Due to (or as a consequence of) certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) use as the buria nding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 To the Hospital or Attending Physician: The within 24 hours a 'er decth.

To the Funeral Director: After this certificate I 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident
Suicide 2 No Investigation th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on

Registrar

DHMH 17 Rev 06-2011

State

29b. Signatu

title of ce

Eugenio Machado, MD

OCT 15 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

29c. License number

D24035

3110 Gracefield Road, Silver Spring, MD 20904

29d. Date signed (Month, Day, Year)

October 12, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Ann Wooters 2012 8:45 Αм October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Centreville Corsico Hills Nursing Home Oueen Anne Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 213-18-4888 Maryland Director 1 M 2 X F 92 Dec. 19, 1919 ifiled within 72 hours are.....tal Hygiene.
ed other than "natural", or items 23a or 28a-f shows event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Centreville Oueen Anne 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 Armstrong Avenue 21617 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 _{Spe}White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Certified Nurses Aid 12 Be traumatic event, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Usilton Georgia Etta Hyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie K. Wooters/ Daughter 5549 Galestown Newhart Mill Rd., Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Junior Order Cemetery 10/12/12 Preston, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 212 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition hEIME Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Yes 2 No 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by omyogathy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ည 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 Q Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number CKNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARShalee Dr 6095 ARIE State Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar Amended #5 per fh 10/16/12 Certificate of Death CCHD AS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 10:00 PM Helen B. Wroten 2012 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline 325 Buena Vista Avenue Federalsburg Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 18-16-667 Hours 90 Director 1 □ M 2 🗓 F Sept. 10,1922 Maryland Usual Residence of Decedent or than "natural", or items 23e or 28a-f show the Mcdical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Federalsburg Caroline 1 tv Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 Funeral United States 325 Buena Vista Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours efter 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 😾 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) perrit. Page 1 and 2 should be filed within 72 Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "any injury or other traumetic event, the Mes Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Inspector 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Hartman William Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4617 Williamsburg Church Rd., Hurlock, MD 21643 Leon Wroten, Jr./ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Federalsburg, Maryland 10/11/12 Hill Crest Cemetery 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee May 23a. Part 1. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease disease or condition 200-607 Coronary Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed | Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, 2 🗹 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 29b. Signature 29d, Date signed (Month, Dav. Year) 00053255 10 2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) freston MD 21455 3683 89 Fank Melinda Butter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:58AM reraldine lilson 2017 tober Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Adventist Takoma Park Montgomer Washington 9. Birthplace Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex (State or Foreign 7. Age (In vrs. fast birthday) **Funeral** Hours Min 78 579-48-8996 Director 1 M 2 X F 07-01-1934 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 1 X Yes 2 No MD Prince George's Hyattsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 23a 20782 United States 3705 Nicholson Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. ō by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates Specify: "natural" 3 X Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government File Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha Dodge Edwin Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43560 Little Cliffs Rd. Hollywood, MD 20636 Kenneth J. Wilson/ Son 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 10-15-2012Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) .Lincoln Crematory 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of uneral Se 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonio disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? o Month Dav Year Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 Yes 2 No 3 Probably 4 Unknown Diobetes should 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a Was an page 2 autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) FIM who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Takoma Park Avenue arroll

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Marylan		rtment of l		and M	ental Hy	giene Reg. No. 2 () 12	35017
	Blandain	.,	1. Decedent's Name (Geraldi	First, Middle, L	ast)	nn.	Och	incate of i	Jeann		2. Date of De	ath	Year	3. Time of Death 12:35p M
	Physicia Medic	al	4a. Facility Name (if no					4b. City, Town, o	or Location	of Death	Month 10		12ty of Death	. Z G G P M
	Examin	er	Prince				enter	Chever	ly			Prin	ice G	eorges
	Funeral Director		5. Social Security Nun 251-52-8 Usual Residence of	3699	Sex 1 ☐ M 2 ☐ ¥	7. Age (In yrs. I	3 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 3 / 1 2 /	th gy, Year) 1939	Coun	olace (State or Foreign try) ginia
	yland •f show ed at	ctor		10b. County			y, Town or Loc shing						1	0d. Inside City Limits
	the Mar a or 28a be notifi	Funeral Director	10e. Street and Numb		NE			10f. Zip Code 20019				10g. Citizen o	f What Cour	
	eath with tems 23 er must	Funer	11. Marital Status			edent Ever in U.	S. 13. W	/as Decedent of F Yes, specify Cub	Hispanic Ori	igin? (Spec	cify Yes or No-	14. Ra	ace - Americ	
036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. and Mental Hygiene. marked other than "hatural", or items 23a or 28a-f show marked other than "matic event, the Medical Examiner must be notified at	by	1 ☐ Never Marrie 3 ☑ Widowed 4			2 🙀 No ve		Yes 2X No			nouri, dien,		fy: Bla	_
15-0	72 hour n "natu fedical	Completed	(Speci		grade completed		(Give k	ent's Usual Occu ind of work done NOT use retired	during mos	at of working	ng	16b. Kind of	Business/In	dustry
212	led within Hygiene. other that		Elementary/Secon		5:	1-4 or 5+)	1	acher						School
/and	ild be filed Mental H narked ot atic even	To Be	17. Father's Name (Fit Charlie	H. Sa	adler				Ize	er's Name etta	Colen	, Maiden Surnai nan	me)	
Maryland 21215-0036	2 sho th an 27 is trau		19a. Informant's Nan Timothy			son	19b. Mailin 1130	g Address (Street	and Numb	er or Rural VE Wa	Route Numbershing	er, City or Town, gton, I	State, Zip 0	19
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Dispo 1 X Burial 2 4 Donation	Cremation 3		n State	cemetery, crem	sition (Name of natory or other pla		_	nate 15/12	20c. Location Quant:	-	own, State Virginia
Balti	permit. Page 1 a Department of H Important: If ite any injury or otl		21. Signature of Fund	eral Service Lice	ensee	MO13				5635	Eads	St. N	E Was	hington 20019
	Inglician/ Medical Examiner		23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List onl _! inal	a. Due to	caused the deal each line.							RE	Approximate nterval Between Onset and Death
1	sit	Examiner	Sequentially list con- if any, leading to im- cause. Enter Underly Cause (Disease or in	mediate ying	Due to	(or as a conseq	uence of):	- 1						
	ate be executed hysician and the burial-transit	dical Exar	that initiated events resulting in death) La		c. Due to	(or as a conseq	uerice of):	bettly		MIX	4			
68760	ficate t g phys as the	Medic	IF FEMALE:		d									
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent print the past 12 mm 1 Yes 2 Unknown	onths?	1 🔲 Liv	utcome of pregnate Birth 2 Fet Egnant at time of known	al death 3	Ectopic pregnar Other (specify)	ncy				Date of deliv	rery Day Year
, P.O.	es that the signed by i	δ	Part II. Other signific	cant condition	s contributing to	death but not re	sulting in the u	nderlying cause ç	given in Parl	t I.		tobacco use co		he cause of death?
cords	law requir has been : je 2 should	Completed									24a. Was	s an 24l opsy formed?	prior to co death?	opsy findings available ompletion of cause of
E Be	sician: The law r certificate has b lirector, page 2 s	Be Co	25. Was case referred	d to medical	T			26.	Place of De	ath (Check	1 🗌 Yes		1 Yes	2 🗆 No
Vit ₂	nysicia nis cert I direct	To B	examiner?	(Mo	Hospital:	Inpatient 2	1	nt 3 DOA Ot	her: 4 🗆 N	Vursing Ho	me 5 🗆 Res	idence 6 🗆 C	ther (Specif	γ)
n of	iding Pt th. After the funera		27. Manner of Death 1 Datural 2 Accident	5 Pending Investiga	(Mc	e of injury onth, Day, Year)	28b. Time of injury	28c. Inju wo M 1	ıryat rk? ∐Yes 2.[- 1	28d. Describe	how injury occi	urred	
Division of Vital Records,	al or Atten s after dea I Director: ed in by the	Certificate;	3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Plac	ce of Injury - At h ding, etc. (Specif	ome, farm, stre	eet, factory, office)			(Street and Num wn, State)	nber or Rura	il Route Number,
1	n 24 hours n 24 hours ne Funera sletely fille	Medical	(Choole 2	Modical Ev	aminer: On the h	add of evamination	on and/or inves	occurred at the tir tigation, in my opin death occurred a	nion, death o	occurred at	the time, date	and place, and	due to the ca	ause(s) and manner stated.
ソ			29b. Signatu and t			4.1	ภ		se number	7		29d. Date sig		
	Jon		30. Name and addre	ess of person wi	no completed ca	use of death (Ite	m 23a) (Type, F	rnum S	+ nc	Wa	shinto	n Del	200	./7
	Sta Registr		31. Date filed (A	Pay Year) 2	112 Se	Registrar's Sign		Red		3 - 97				
	gip.		110	II A ·A ·			11.00							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death WEST 2012 0738 AM Physician/ STEPHENS MYR7LE . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month. Day, Year) Months Hours Min. 434-48-6705 Director 1 □ M 2 🖾 F 77 March 31,1935 Temple, Louisiana Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a. State at the Maryland Director ms 23a or 28a-f s must be notified 1 🛛 Yes 2 🗌 No Maryland | Hyattsville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 6919 Freeport Street USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. ıral", or item Examiner n Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican. etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Own Home Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker 2 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ William Ralph Stephens Jane Killian Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6919 Freeport Street, Hyattsville, MD 20784 Tina M. Rollason / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10/17/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 No. 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final ARRHYTMIA FATAL Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertension 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 X 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number D74857 8,2012

State Registrar

DHMH 17 Rev 06-2011

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4)00400

32. Registrar's Signature

HOSPITAL DR CHEVERLY MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NeiAGU

USI L BEVICE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ October 9, 2012 8:40 a M Roberta Virginia Wilson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Director 1 M 2 K F 579-36-9118 sual Residence of Deced August 30, 1931 DC 81 filed within 72 nous accessed the Hygiene.

ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Prince Georges Clinton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 Mardella Blvd 20735 JSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No ٥ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Brown Alberta B. Lawson end 2 should be Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Mardella Blvd Clinton, MD 20735 Wanda L. Okoro - daughter injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park | October 18, 2012 | Largo, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Sewell Funeral Home, P.A. Bladen 1451 Dares Beach Rd. Prince Frederick, MD 20678 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PERCAPN Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi 4(15051 4071 that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Komonard Box 68760 erei Director: After this certificate has been signed by the ettending phys filled in by the funeral director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 ☐ No **Division of Vital** ospital or Attending Physicien: hours after deeth. unerei Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ှင 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural Investigation 6 Could not be 1 Yes 2 No Ascident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funerei C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) KW ath (Item 23a) (Type, Print) who completed cause 8

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 35020 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **20**12 Year Martha Wolf October 10 9:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Citizens Care & Rehabilation Center Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 215-74-8272 Days Hours Director 95 1 M 2 X F Maryland Nov 23, 1916 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director 28a-f Frederick Frederick Maryland 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21702 ŬSA 1920 Rosemont Avenue items 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo the Medical Examiner Black, White, etc ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Give 1 ☐ Yes 2X No Specify. 'natural", Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H frem 27 is marked of other traumatic ever Clifford Smith 2 Viola Mae Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, f Health a 21755 3718 Jefferson Pike, Frederick, Maryland Tom Arnold - friend injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Page 1 s 1 Burial 2 Cremation 3 Removal from State Weller U.M. Church 10-15-2012 Thurmont, 22. Name and Address of Facility Stauffer Funeral Home 4 Donation 5 Other (Specify) Thurmont, Maryland 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rement disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Bron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 m Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 LINE be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Completed 1 🗌 Yes 2 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) 2 🚺 မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner et eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 8 Vatural injury work? 1 Yes 2 No 5 Pending the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 10-11-12 MD

Registrar
DHMH 17 Rev 06-2011

State

Frederica MD 21702

Thomas

Registrar's Signature

Merch.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

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Day, Year)

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of IV	laryland		artment of F tificate of E		na ivienta		erie 2 0	12	35021
Ī	Physicia		1. Decedent's Name (First, Midd Maureen	H. M.		Wo1f	е			e of Death nth ober	9 ^{Day} 201	2 ^{Year}	3. Time of Death 12:45 PM
	Medic Examin		4a. Facility Name (if not institutio	on, give street and number) Valley Flint	Pood		4b. City, Town, or				4c. County		
	Funeral Director		5. Social Security Number 103-22-4137 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min. (Mc	e of Birth onth, Day, \			place (State or Foreign try)
	aryland a-f show fied at	ector	10a. State 10b. Count			Town or Local						1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	vith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Number 7456 Eylers	Valley Flint	Road		10f. Zip Code 21788			10	Og. Citizen of N	What Cour	try?
9036	e filed within 72 hours after death with the Maryland that hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Von Civo	?	l If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, F	- ? (Specify Yes Puerto Rican, e	s or No- etc.)		e - Americ ck, White, e	
Baltimore, Maryland 21215-0036	in 72 hou e. han "natu Medical	Completed		lent's Education hest grade completed) College (1-4 or	5+)	(Give k	lent's Usual Occup kind of work done of O NOT use retired)	luring most o			16b. Kind of B		
d 21	ed withi Hygiene other th ent, the	o l	17. Father's Name (First, Middle,	2		Loan	Service I				Mortgas aiden Sumam		nking
ylan	should be filed of and Mental Hyg 7 is marked other traumatic event,	은	Vincent Howle						leen O		•		
, Mar	d 2 shou alth and 1 27 is n er traum		19a. Informant's Name/Relation: Daria C. Moffa		11		g Address (Street a Eylers Va						
nore,	age 1 an ent of He it; If iterr y or othe		20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other		e cer	metery, cren	sition (Name of natory or other plac	i .	Date		20c. Location	,	wn, State Maryland
Baltir	permit, Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once.		21. Signature of Funeral Service		Sta	22	cremator Name and Address C21 Oposs	s of Facility	Stauffe	r Fur	neral H	lome	
				or complications that cause tonly one cause on each lir	ed the death.							, mar	Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a conse ue		ncer					-	Onset and Wath
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s à conseque	nce oi).							
	sate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
200	ate be e physicial the buri	edical		d								4	
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3 🗌	Ectopic pregnand Other (specify)	у				ate of delive	ery Day Year
ls, P.O.	uires that the signed by ald be deta	by	Part II. Other significant condit	tions contributing to death	but not resul	lting in the u	nderlying cause giv	en in Part I.	23			- 1	ne cause of death?
Division of Vital Records,	The law require: cate has been siç page 2 should b	Completed							-	la. Was an autopsy perform Yes 2	ned2		osy findings available mpletion of cause of 2 No
Vital	ysician: is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 E	R/Outpatier	Oth		(Check only o	-	nce 6 🗆 Oth	er (Specify)
n of	nding Ph th. : After th e funeral		27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	28a. Date of ing (Month, Date)		28b. Time of injury	work	/ at	28d. De		v injury occurr		
ivisio	I or Atter after dea Director d in by the	Certificate:	3 Suicide 6 Coul	d not be 28e. Place of In	ijury - At hom tc. (Specify)	ne, farm, stre	eet, factory, office		28f. Lo	28f. Location (Street and Number or Rural Route Number, City or Town, State)			Route Number,
ш	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical	ng Physician: To the best of I Examiner: On the basis of ng Nurse Practitioner: To t	examination a	and/or invest	tigation, in my opinio	on, death occu	urred at the tim	e, date and	l place, and du	e to the ca	use(s) and manner stated.
	To the within To the comp	2	29b. Signature and the of certifi		MD		29c. License		ł.		d. Date signe		
	15		30. Name and address of person	n who completed cause of	death (Item 2	23a) (Type, P	Print)	Fred	ecic	V n	V) :	217	02-
İ	Sta Registra		31. Date filed (Month, Day Year)	2 2012 /32/Regist	trar's Signatu	5. p	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35022 For State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month 9:05 A M Physician/ 2012 MYRTLE MAE STANFIELD WHITE 10 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** WILLIAMSPORT WASHINGTON HOMEWOOD AT WILLIAMSPORT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-28-4077 1 □ M 2 🛛 F Director 101 MAY 23, 1911 Usual Residence of Decedent 10d. Inside City Limits permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "neture!", or items 23e or 28e-f show injury or other treumetic event, the Medical Examiner must be neithed ≇t solos. 10c. City, Town or Location 10a. State Director WILLIAMSPORT 1 🗌 Yes 2 ី No WASHINGTON MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 USA 16505 VIRGINIA AV. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done of life. DO NOT use retired) during most of working **EDUCATION** Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CARL T. McMILLAN LILLIAN DRAKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6591 COLEBROOK LANE, MIDDLETOWN, MD 21769 EDWIN G. STANFIELD / 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/10/12 FALLING WATERS, WV HARMÓNY CÉMETERY ess of Facility BROWN FUNERAL HOME, P.O. BO 327 W. KING ST, MARTINSBURG WV 25402 22. Name and Address of Facility 21. Signature of Funeral Service Licensee obert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line. Pnysician/ Medical Examiner attending physician end for use as the burial-tran Division of Vital Records, P.O. Box 68760

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Medical

29a, Certifie

29b. Signatur

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only one

Hospitei or Attending Physicien: The lew requires that the death certificate be executed ed by the a within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director,

State

	disease or condition resulting in death)	a. Due to (or as a consequ	ence of):				0/6/6	<u>, 47 Z</u>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin.	b. Due to (or as a consequ	uence of):					
- CO	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):					
SICIAL VINCA	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	al death 3 🗌 Ectopic			23d. Date of de Month		/ear
יווא למום	Part II. Other significant conditions of		ulting in the underlying	g cause given in Part I.		o use contribute t		
ompiere					24a. Was an autopsy performed′ 1 □ Yes 2 ➡	prior to	utopsy findings a completion of ca s 2 \(\square\) No	vailable ause of
ע ע	25. Was case referred to medical			26. Place of Death (Che	eck only one)			
0	examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3 🗆	Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Spe	cify)	
care:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, facto	ory, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Numb	er,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

partifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #23b Per MD FCHD TM 10/12/12 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT 20^{Year} YONG PING ZHANG 1:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY COLLINGSWOOD NURSING CENTER ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Hours 10/10/1929 CHINA 230-37-5064 Yrs Director 83 Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY ROCKVILLE 1 Yes 2 No MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 299 HURLEY AVENUE 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: ASIAN Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me KITCHEN HELPER Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ZHE GUI ZHANG DA YING LIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 635 DAWSON TERR., HUNTSVILLE, AL 35811 CHAO BIN ZHANG / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 10/20/2012 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Fer ice Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performe After this certificate Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🛂 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Matural work 24 hours after death. Funeral Director; At 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death
To the Funeral Director, of completed filled in by the incompleted filled filled incompleted filled fil Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (er Kariya 30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) B 1 0 31. Date filed (Month. 32. Day, Year Registrar's Signature State

Registrar

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shawna Adams	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No.	3502
Physician/	Registrar 2 Date of Death	3. Time of Death 2228 hrs
edical Examiner	1. Decedent's Name (First, Middle, Last) Dashawa Adams Month Day October 24, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	14
)	Johns Hopkins Hospital Ped. ER Baltimore	A State or
Funeral Director	7[-05][07][1.10]	ntry) Mary land
any.	10a. State 10b. County 10c. City, Town of Education	10d. Inside City Limits
yland I-f show Conce.	Maryland N/A Battimore 10e. Street and Number 10g. Citizen of What Count	
the Maryland is or 28a-f shortified at one	2828 E. Madison St. 21205 USA	
within 72 hours after death with the Maryland spiene. For than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once. Ompleted by Funeral Director	11. Marikal Status 12. Was Decedent Ever in U.S. 14. Race - Americal Never Married 2 Married Never Married 2 Married 1 Pivorced If Yes 2 No Specify: 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 16. Race - American White, etc. 17. Yes 2 No Specify: Speci	an Indian, Black,
urs after ntural", aminer d by	3 Widowed 4 Divorced of Specify: 1 Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/In	idustry
5-0036 led within 72 hours after tygene. other than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) Student	
予 3 表 3 知 つ	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19c. Marison St. Battimore	Zip Code) 205 Maryland
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or T 1 Burial 2 Cremation 3 Removal from State	
Page Page or ot	4 Donation 5 Other Specify: 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Park Funeral Home.	Maryland
Balti permit. Departm Importa injury o	Slyin tarker 3572 Frederick Ave Battimore Ma'r	Variate Interval
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
tted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
0, be executed sician and burial - trans	■ MENDED 23a,27,per me,g935 1-14-13 sm	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwiting 24 hours after death. To the Function: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial certification: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 23d. Date of delivery Month D	ay Year
D. Boy the deat by the att ached for	1 Yes 2 No 9 Unknown 9 Unknown	the cause of death?
ires that the signed by I be detacl		ably 4 V Unknown
Records, The law requires ficate has been sig	autopsy performed? death?	ompletion of cause of
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical	s 2 No
Vita Physicia This certail direct	1 Ves 2 No inpatient 2 Ervoupatient 3 DOA 4 Transmittened 5	:
ion of V tending Phy eath. tor; After the the funeral		
Division of Vital Records, spital or Attending Physician: The law require hours after death. Caral Director: After this certificate has been si filled in by the funeral director, page 2 should be contification. To Be Completed.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rule or Town, State)	ral Route Number, City
Division To the Hospital or Attent within 24 hours after death within 24 pirreforar completely filled in by the	1 298. Certifier 4 1 a 445 to 5 Shorteless. To the heat of my knowledge death occurred at the time date and place an	e cause(s)
To the H within 24 To the FI complete	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and does to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor	
	0.C.M.E. October 25, 2012	<u> </u>
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stat Registra		

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $\overset{Month}{10}$ Ashley 30^{Day} 2012° 4:38 Physician/ J. Kathryn Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Anne Arundel Genesis HealthCare If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🛣 F Hours PA 193-12-7075 Months 1 123-1925 87 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at rector Anne Arundel Severn 1 Yes 2 No MD ā 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21144 Funeral 1463 Washington Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces'
1 X Yes 2 Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Government Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gunkle Emily ည Greenawald George Elias 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Magnolia Road, Glen Burnie MD 21061 Brenda Stoehr/daughter 20a. Method of Disposition 1 Durial 2 Crer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State Crownsville, MD 11/5/2012 MD Veterans Cemetery Donation Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home f Funeral S M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the cheeks, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ ehrou disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 hably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 performe 1 Yes 2 No 1 Yes 2 7 25. Was case referred to medical 26. Place of Death (Check only one) director. Certificate: To Be examiner? 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur within 24 hou To the Fune completed fil

> State Registrar

Medical

29a. Certifier

(Check only one 29b. Signature and title

30. Name and address of 70v 31. Date filed (Mo

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Swalls 2/08 D. Dunk Drive Cheft, MD 2/619

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 35026 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Judith Behrens 12:43 PM October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 8, 1940 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Country) Director 481-46-5273 72 Iowa Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 28a-f 1 Yes 2 No Harford Forest Hill Maryland 10e. Street and Number 23a or 10g. Citizen of What Country? Funeral I 21050 USA 2507 Ridgeview Drive . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 ☐ Never Married 2 X Married 1 Yes 1 Yes 2 XNo Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. larked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Louis (unk) Kapfer Clara (unk) Volk of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Behrens / Husband 2507 Ridgeview Drive, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 11-5-2012 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs. LLC Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEPATIC ENCEPHALOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** GASTRO INTESTINAL NUMS, MUGARET #MOCOCAISH Division of Vital Records, P.O. Box 68760 C.S. Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DMI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy mondo upopenia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 657 33 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESAPEOKY Medical Health HOSPITALIST V. PULA NARAYANA RAO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

NOV 0.2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10 Thirza May Brandt 2012 18:45 PM[™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 218-05-2574 1 □ M 2 🔀 F **Director** 01/13/1917 95 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 No MD Baltimore Upper Falls 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ö be Funeral 23a must 11403 Raphel Road - Box 2 21156 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or iter Examiner Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other tha 12 Buyer/Sales Representative Retail Sales Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Bagley Price Bertha May Bond and lisimis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lambert Boyce, Jr. (executor) 9515 Deereco Road, Suite 500 - Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State John Epis.Ch.Cem. 11/03/2012 | Kingsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Examiner phagiti's Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by brila tron 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 N Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital of 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Frectitioner To the best of my knowledge, Seath Documed at the time, date and place, and due to the name (it) and manner as starked To the Within 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Milutyanskaya

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

NOV 0 2

0131112

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legipie. amend Item | per doc g933 I I - 2 - 12 vt | State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10-Month Physician/ 6:30P M 26-2012 JoAnn Jumper Berry JO A. JUMPER Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death PALMER HOUSE NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthph... Country) NC (Month, Day, Year) 08-07-1941 Director 1 □ M 2 🛣 F 244-64-2218 71 Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 616 WOODBOURNE AVE 21212 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 ☐ Never Married 2 🛮 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) GUIDANCE COUNSELOR BCPS SYSTEM Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည THOMAS ED JUMPER SADIE MAE GRIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN BERRY/HUSBAND 616 WOODBOURNE AVENUE, BALTO., MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State METRO CREMATORY 10/31/12 BALTO., MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MOROTN & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End-Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attanding physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No fillad in by the funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Dones Specify Ning FACILITY 2 🗗 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Prestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complately Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DODS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. REGIONAL SEMINO 2+3.5 SARN IV S 203 Baltimore MD Z1209. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 pm Medical institution, give street and number) 4a. Facility Name (if no 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** If Under 1 Year Days Min. 1 M 2 □ F Director RVLAND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 W No 10e. Street and Number 10g. Citizen of What Country? 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: WhITE 3 Divorced Year or Dates. 1960 - 62 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1CIA. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JRAD** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET BRATCHER 7466 EXENACE BRANCHAD. 40T.410G XN1E, MD. 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ODENTON. 11-5-12 22. Name and Address of acility DaughERTY TUNERAL HOME MOC44Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 Weelh disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transi and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Yes 2 □ No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 1 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2716 10 30 cause of death (Item 23a) (Type, Print 30. Name and address of person who a

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Beamon Month 0 Physician/ 20 Year Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Caton Bellemore Mora If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Hours Min. (Month. 1 🗆 M 2 Director N.C. Usual Residence 28a-f show 10d. Inside City Limits 10a, State Town or Location notified at Funeral Director Baltimore 1 Yes 2 No MD ine. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? items 23a or ner must be n 2504 Marbourne Ave. 21230 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Medical Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Never Married 2 Married ö \$ 2 No ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Center the Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Beamon Page 1 and 2 should be eander Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica Williams - daughter Ave. Marbourne Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Zion Cemeten 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Hiss Balto, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final Physician/ neumonis disease or condition Medical resulting in death) **Examiner** arteno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be or 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicisis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate has ral director, page 2 2 🗆 No 1 Yes Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 6 Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannu eath Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death control in the cause (s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number Ò 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signati State NOV 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert 09:00 AM Medical 10 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rejuvenation Assisted Living Silver Spring Montgomery 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 502-12-1826 1**XX**M 2 □ F 87 May 11, 1925 Minnesota ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7414 Linnean Ave. NW 20008 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 9 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–46 1 Yes 2XX No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (General Electric Co.) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien? Representative Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cassins Barrie Anna Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Paula B. Barrie / Wife 7414 Linnean Ave. NW, Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/01/2012 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Signature of Funeral Service Licensee Sei 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Very Immediate Cause (Final Advanced Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any least sequentially cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence dry that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 N death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other:
4

Nursing Home 5

Residence 6

Other Specify 15 4

Nursing Home 5

Residence 6 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After thi etely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation
6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one

DHMH 17 Rev 06-2011

Registrar

Dr.

Suite Gr. Linthicum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0 2 2012

705 Digital

10, 29, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bagirova 2012 October 24. 5:00pm M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6810 Park Heights Ave. Apt. 204 Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 214-43-9228 **Director** 73 1 M 2 X F 8-26-1939 Azerbaijan Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 6810 Park Heights Ave. Apt. 204 21215 United States items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bronstein Valentina Gogoleva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Lev Bagirov (son) 30 Stridesham Ct. Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State - 5 Department of Important: If any injury or once. All Saints Cemetery 10-29-2012 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road 21136 J. Wayne Osterling Eline Funeral Home Reisterstown, MD se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner redole Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be swithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the built of the funeral director, page 2 should be detached for use as the built of the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copribute to the cause of death? þ 1 🗌 Yes 2 1 No 3 Probably 4 Unknown Completed Hyperlipidence 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 2 No Yes 2 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Graphing Nurse Fractitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 27,2012° VINCENT J. BONADIO, SR 8:14 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8810 WALTHER BLVD. APT. 1430 BALTO PARKVILLE **Funeral** 7. Age (In vrs. last birthday Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 218-03-8010 93 **Director** 1 🗚 2 🗆 F MARYLAND 10-13-1919 Usual Residence of Decede 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director BALTO. PARKVILLE 1 Yes 2 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 WALTHER BLVD. APT. 1430 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S.
Aspect Forces?
1♣ Yes 2 □ No
If Yes, Give
Year or Dates. 1944–1946 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or ģ Baltimore, Maryland 21215-0036 1 Yes 2 No should be filed within 12 norm. It and Mental Hyglene.
27 is marked other than "natural. 3 X Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ary/Secondary (0-12) College (1-4 or 5+) 8TH STEAMFITTER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FELICE W. BONADIO EMILA TORCHIA 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. ROSEDALE, MD. 21237 CHARLES E. BONADIO 5422 BALISTAN ROAD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11-2-2012 BALTIMORE, MD MOST HOLY REDEEMER 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. ull 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ AJCVO disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pisease or injury Examine Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Month Day Year 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown been si should Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy perform death? certificate 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of I Director: After to in by the funeral 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completely filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 29 H D53115 7015

5X

State Registrar 31. Date filed (Month, Day, NUA U

Lundsman

30. Name and address person who completed cause of death (Item 23a) (Type, Print ff00

Walth

DHMH 17 Rev 06-2011

Parkville

21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Registrar 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) October 27, 2012 11:20 AM Physician/ Clayton Carl Brindle Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) Examiner Montgomery Rockville Alfred House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 187-14-0694 89 Director 1 1 x M 2 □ F Nov. 22, 1922 Pennsylvania Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryiand ment of Health and Mental Hygiene.

tant: If itam 27 is marked other then "natural", or items 23a or 28e-f show into or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 X Yes 2 ☐ No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20851 United States 1213 Parrish Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: If Yes, Give WW II White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry during most of working United States College (1-4 or 5+) Elementary/Secondary (0-12) Department of Navy Aerospace Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Grace Garner Clayton Harvey Brindle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9205 Winterset Drive, Potomac, Maryland 20854 Deborah B. Sisman/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If its any Injury or ot Nov. 3 2012 Huntingdon 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State River View Cemetery Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sucden Immediate Cause (Final Arteriosclerosis Generalized Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Years Examiner Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Arteriosclerotic Cerebrovascular Disease Years Exami To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit that initiated even Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Years Age and Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Veat 5 Other (specify) 1 ☐ Yes ∠ □ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Myocardial Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Prostate Hypertrophy autopsy performed? Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Hypertension 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Assisted 4 Nursing Home 5 Residence 6 Dother (Specify) Living examiner? 1 ☐ Yes 2 🖾 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

15+1

DHMH 17 Rev 06-2011

State

Registrar

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oliver J. Lawless, M.D.

NOV 0

31. Date filed (Month, Day, Year)

7)25410

18111 Prince Philip Drive #1310, Olney, Maryland 20832

October 31, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year, 1/13/48) Country) 214-50-9268 Director 64 1 🗆 M 2 💢 F MD or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Anne Arundel Brooklyn Park 1 🗌 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 21225 USA 5105 Brookwood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", Completed 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or cat. L. Jackson Mary Ε. Geisler Zane be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8300 Grainfield Road, Severn MD 21144 Anita I. Doda / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕱 Burial 2 🗌 Cremation 3 🗆 Removal from State Meadowridge Cemetery 10/26/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ week disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transi that initiated events Due to (or as a cons resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death signed by the a ld be detached f 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature

State Registrar

DHMH 17 Rev 06-2011

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12-08159 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Roland James Bopp 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 27, 2012 Roland 1154 hrs James **Medical Examiner** Bopp 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Atlantic General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Hours Min 217-68-0169 6-22-1956 Director 56 Country) MD 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Any 10a. State 10h Count 10c. City. Town or Location Sussex DE 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. Selbyville death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 37070 Blue Teal Road U.S.A. 19975 Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes . Pages 1 and 2 should be filed within 72 hours after de ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or or other transmatte event, the Medical Examiner nu White If Yes, Give Year Specify: 3 Widowed 4 X Divorced 1 Yes 2 X No specify: 2 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bopp Services Baltimore, MD 21215-0036 Handyman 10th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roland James Bopp Sr. Be Doril Loretta Schuchardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister (Bopp) LewANDIUSK Paula L. 37070 Blue Teal Rd. Selbyville, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XCremation 3 Removal from State Odenton, Maryland West Arundel Crem 11-2-12 Donation 5 Other Specify 22. Name and Address of Facility $\,$ Joseph $\,$ N $\,$ 21. Signature of Funeral Service Licenses Zannino Jr F.H. Conkling St. Balto. Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death Tramadol and Morphine Intoxication Immediate Cause Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g933 11-14-12 sm X UNPENDED signed by the attending physician be detached for use as the burial ģ Completed

The law requires that the death certificate be Division of Vital Records, P.O. Box 68760. this certificate has been a director, page 2 should Be Certification:

2

ca

29b. Signature and title of certifier

State 31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

FEMALE:	23c. If yes, outcome of pregnancy		23d. Date of de	elivery	
Bb. Was decedent pregnant in the	1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day	Year
past 12 months?	4 Pregnant at time of death 5 Other (Specify)				
Yes 2 No 9 Unkno					
		On- Didu-t-		4 - 4 - 41	f -l
art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribu	ite to the caus	e of death?
Hepatic Cirrho	sis	1 Yes	2 No 3	Probably 4	✓ Unknown
		24a. Was an autopsy		ere autopsy fin- or to completio	idings available
		performe		ath?	iii oi caase oi
		1 ✓ Yes 2	No 1	Yes	2 No
5. Was case referred to medical	26.Place of Death (Check	only one)			
examiner?	Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursi	ng Home 5 Re	sidence 6	Other:	
1 ✓ Yes 2 No					
7. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? (Month, Day, Year)	28d. Describe hov			
1 Natural 5 Pending	1 Vas 2 vr No	subject	ingeste	d medic	ation
2 X Accident Investig	fd 10-27-12 fd 10:54am	001 1 11 101		- B - I B - I	N. b. Oil
3 Suicide 6 Could n	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street or Town, State	et and Number	RILLA TO:	a 1 RA
4 Homicide determin	(Specify) vehicle	Selbyvil	le, DÉ.)	ul Ku.
9a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s	and manner a	s stated.	

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 28, 2012

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 11.55 P M Physician/ Mary E. Bevil Medical 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BUZHIE BACTIMORE WASHINGTON MEDICAL Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) Social Security Number If Under 24 Hrs. **Funeral** Months Hours 217-26-3854 Director 1 □ M 2 🖾 F 81 Nov. 19, 1930 Virginia Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location Director 1 Yes 2 X No Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21061 312 Glenwood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Emma Frost Noah B. Jarrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 312 Glenwood Ave., Glen Burnie, Maryland 21061 Timothy C. Bevil / Son Baltimore, | 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date October 2012 20, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 22, Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., 21. Signati e of Feneral Ser Funeral Home, P.A. SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCIDENT Physician/ EREBRINAS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) tate has been signed by the spage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) Burnie MD 32 Registrar's Signature 31. Date filed (Month, Day, Year State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	1 - State of Maryland / Department of State of Maryland / Department of Certificate of Registrar			giene Reg. No. 🤈 🕦 📗	2 35038
	Physicia		1. Decedent's Name (First, Middle, Last) Annie Mae Creasy		2. Date of Dea	er 27,20°	3. Time of Death 12 12:44 PM
-	Medic Examin	al .	4a. Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death		4c. County of D	eath
1		м	Castle of Love Upper 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	Marlboro	8. Date of Birth		George Co Birthplace (State or Foreign
ш	Funeral Director	ľ	5.79-32-1866 1 Months Da		(Month, Day 05/30	Year) / 1921	Country) North
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			ICa	arolina 10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Prince George Upper Marlbor				1 ☐ Yes 2 🛣 No
	ith the		10e. Street and Number 10f. Zip Cool 14711 Mount Calvert Road 207			10g. Citizen of What USA	Country?
36	I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It manked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 20 or 28a-f show other traumatic event, the Medical Examiner must be notified at	by F	11.7.1.110	of Hispanic Origin? (Sp Juban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W Specify: A	merican Indian, //hite, etc. frican-
2-00	hours 'natura'	plete	15. Decedent's Education 16a. Decedent's Usual Oc	cupation ne during most of work	ing I	16b. Kind of Busine	nerican ess/Industry
21215-0036	within 72 /giene. ner than ' t, the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retire 8 House Keep	red)		Self-er	mployed
nd 2	be filed w ental Hygi ked othe ic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	_	Maiden Surname)	
Maryland	should be file and Mental I is marked c raumatic eve	입	Samual Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str	Corne		hnson City or Town, State	Zip Code) ,20772
	and 2 shou Health and tem 27 is m		Tillie Howard (Daughter) 10003 Gol	denwood (ct. Upp	er Mari	ooro GM
_			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	MD ^{e)} 11/0	Date 2/2012	Hanover, M	aryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signatu o neral Serie Censee John F. Holmes 22. Name and Ac M01464 4111 E	Idress of Facility Ce (Pennsylva)	dar Hil nia Ave	l Funera Suitla	al Home Inc nd MD 20746
)	nysician/ Medical		23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or a a consequence of):	ure		rest,	Approximate Interval Between Onset and Death
76	cate be executed bhysician and physician and sthe burial-transit	edical Examiner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	tailur	£		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of Month	f delivery Day Year
s, P.O.	requires that the book is been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did to	1	te to the cause of death?
of Vital Records,	n ysician: The law requ nis certificate has been I director, page 2 shou	Completed by			24a. Was autop perfo	osy prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
/ital	rsician: s certifii director	To Be	25. Was case referred to medical 2 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	6. Place of Death (Checonomic Other:		dence 6 -Other (S	Specify (HS) 1372 VILL
of	iding Phy th. After this funeral		27. Manner of Death 28a. Date of injury 28b. Time of injury (Month, Day, Year) 28c.	Injury at work?		now injury occurred	,
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A completely filled in by the fo	Certificate:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	1 Yes 2 No	28f. Location (S City or Tow		r Rural Route Number,
_	Hospita 24 hours Funera etely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the desired for the desired for the basis of examination and/or investigation, in my of the desired for the desired fo	pinion, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within To th e сопр	Σ	29b. Signature and title of Pertifice 29c. Lie	ense number		29d. Date signed (M	
				059884	†	11/2/2	012
_	2		30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print) Tinisha Cheatham, D.O. 5100 Auth Way Suitland, Mar	vland_20746			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Physician/ Month PM Melvin John Carlson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heirford tizens Nursina Home Havre de Grace 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days (Month, Day, Year) June 8. 1921 Months Hours Min. Illinois 334-16-3556 91 **Director** June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Yorkshire Wav 21014 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No 1947 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ♥ Widowed 4 □ Divorced Completed 1949 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Federal Government Research Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ John Ludwig Carlson Anna Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Moretti, Daughter Deer Hill Circle Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/01/12 Baltimore, Maryland 21. Signature of Funeral Service Licensey Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 /roman 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death dralion Physician/ disease or condition resulting in death) Medical Due to (or as a conse Fence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) To the Funeral Director; After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I prior to completion of cause of autonsy performed? 1 Yes 2 No Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MD 13260 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hours De Gonec

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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MD21078

MILLIAM MD 1106R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AME S Medical 4a. Facility Name (if not institution, give street and number) Examiner Seasons Hospice at Northwest Hospital Randallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 212-38-3829 71 Director 1 1 ₹M 2 □ E April 1,1941 Ohio Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Mudical Examiner must be notified at 10c. City, Town or Location 10b. Count 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Catonsville 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 115 Osborne Avenue 21228 USA death \ Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 3 Married ş hours after Baltimore, Maryland 21215-0036 White Yes Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 t of Health and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Cowles Margaret Zurfluh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Cowles Wife Osborne Avenue; Catonsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11/3/2012 Baltimore, MD 22. Name and Address of Facility Sterling Ashton S Funeral Home of Catonsville, Inc. 21. Signature of Fun and Exervice Licensee Ashton Schwah Witzke 1630 Edmondon Avenue: Catonsville 21228 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequ ence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physicien and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the et d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? ☐ Yes_ eral Director: After this certificaliled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🖾 No Other: 1 Yes မူ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mannin f Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medicai 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 5v

State Registrar

Name and address of person who completed

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician/ romme) Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner tospital Johns Hopkins 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** 245-56-2819 1 □ M 2 🖫 01-13-1928 Director NC 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director BAUTIMOLE 1 X Yes 2 ☐ No Mρ 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21213 POTOMAC 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 KNo Specify: Baltimore, Maryland 21215-0036 Specify: BIACK If Yes, Give Year or Dates 3 🗆 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MORGAN STATE Elementary/Secondary (0-12) College (1-4 or 5+) LOUSE KEEPING 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ Yelverton-Sauls HATTIE EID 19a. Informant's Name/Relationship (Type, Print) (HVS band) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIE CROMWELL BAUTIMORE, Md. 21213 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Battimore, Md 11-6-12 Garden of faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SERVICES 21. Signature of Fune al Ser ice Licensee Road. BAUTIMORE, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician ongestive Medical resulting in death) Due to (or as a consuluence of) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to for as a consequence oil. Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Dav in the past 12 months? Pregnant at time of death 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to g | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2 🗆 No Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 000 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Stor 38,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Duneliese

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

1800

Orleans Street

Baltimore, 40 21287

MD

32. Registrar's Signature

Cuttle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ М chor Medical acility Name (if not institution give styget and number) Examiner dr Location of Death 4c. County of Death If Under Age (In yrs last birthday) If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) **Director** 439-28-4688 1 □ M 2 T F Usual Residence of Decedent 84 20,1928 Maryland er than "natural", or items 23a or 28a-f show the Medical Evanniner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No Maryland | Washington Hancock 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3224 Western Pike 21750 U.S.A. death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) N/A McCormick Company <u>Packer</u> æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any Injury or other traumatic v Injury or other traumatic Edith Gwinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 N. Walnut Street Clovis New Mexico 88101 Lewis Alvin Carter (Son-in-law) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/03/2012 Brooklyn Park, Maryland 21. Signature of Fupéral Service Licensee 22. Name and Address of Facility MOO - 732McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a la consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burlal-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No Yes 2 No **Division of Vital** director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospitai Medica 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signate e-and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 0 2012

State Registrar 30. Name and address of person

a mas 31. Date filed (Month, Day, Year)

Balvic

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who completed cause of death (Item

32. Registrar's Sigg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 9:30p Barbara 2012 Citrano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5240 Freter Road Sykesville Carroll Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 220-38-8848 71 **Director** 1 □ M 2**X** F 02/12/1941 Md. 28e-f shov 10a, State or then "neturel", or items 23e or 28e-f sho 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Md. Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5240 Freter Rd. 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Public Defenders Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager (State Govt) other treumatic event, permit. Page 1 and 2 should be filed Department of Health end Mental Hy Importent: If Item 27 is merked otherny Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Frederick Hardtke Sr. Myrtle Culley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Glyndon Trace Drive Reisterstown, Md. 21136. Amy Citrano (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) all County cremation 11/01/2012 Sykesville, Md. 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Disease Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami The law requires that the death certificate be executed siclen end burlal-tran Due to (or as a consequence of) resulting in death) Last the attending physiclen thed for use es the burla Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Year n signed by the at ald be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Kunknown been si 24a. Was an 24b. Were autopsy findings available this certificate has rail director, page 2 s autopsy prior to completion of cause of death? 1 Yes 2 No Yes Division of Vital To the Hospitel or Attending Physlclen: a within 24 hours efter death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Mariner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 12 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October James Julian Cromwell 2012 30. 7:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arden Courts Potomac Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 219-34-8777 Director 1 X M 2 □ F 77 February 19, 1935 Washington, D.C. Usual Residence of Decedent ir then "netural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Ves 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? Funeral 20817 7501 Democracy Blvd. #224 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? UNK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Private Practice Attornev Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen C. Cromwell, Sr. Phyllis Spooner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 Hectic Hill Lane, Rockville, Maryland 20854 James J. Cromwell, Jr./Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2, 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) Signature of Fun Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland Miseratta Banava M01305 20850-2805 Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Liner Uniderlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and I for use as the burial-transit Exam Advanced Dementia Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has i autopsy performed? Yes 2 X No 1 Yes 2 🗆 No Be Was case referred to medical 26. Place of Death (Check only one) Assisted Living examiner/ 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Certificate: 1 🖾 Natural 5 Pending injury To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fu 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Continuing Practitioning to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0057458 November 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pinky Singh, M.D. 8218 Wisconsin Avenue, Ste. 305, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year)

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State

Registrar

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Exami		Donald Ch	arles	Cannata		b. City, Town, o	.1		Month October 3			0001 hrs
		4a. Facility Name (if not institution 7725 Suitt Drive	on, give street and n	umber)	14	Pasadena	r Location	n of Death		4c. County Anne A		
ıneral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	_		8. Date of Bir	th(MM/DD/YYY	Foreig	hplace (State or
rector -		216-34-8178	1 X M 2 F	74	Yrs.	Mortins	ys Hou	JIS IVIIII,	10/06/	1938	Cou	^{intry} Pennsy1va
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on		-	_			10d. Inside City Limits
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or items 23a or 28a-f sho must he notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 N	12. Was De Armed F	cedent Ever in U		Decedent of H					e - Ameri te, etc.	can Indian, Black,
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al Hyg		17. Father's Name (First, Middle ${ m Albert}$	Cannata					iers Name (i 115e	rirst, Miladie, n	Maiden Surnam Cascia		
Ment mark	밁	19a. Informant's Name/Relation	-				et and N	umber or Ru		nber, City or To	vn, State	
Ith and 27 is		Donald C. Canna	ita, Jr-Sc							aryland		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nartural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must he notified at once		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal f	rom State	Place of Disposi crematory or oth	er place)	•		Date	20c. Location	-	
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Depart Impor Injury		21. Signatur Funeral Service	Licensee MC	0-732	122. Na MC(ame and Addre	ss of Faci Dlyni	ility Lak Eu:	neral I	Home, P na, Mar	. A	1 21122
sician	\dashv	23a Part I. Enter the disease, o		caused the death	. Do not enter th	e mode of dying	aln g, such as	KOAO . s cardiac or r	espiratory arre	est, shock, or he	y I allic	Approximate Interval
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miner		or condition resulting in death)		a consequence o	of):							
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and transit		events resulting in death) Last	d.	a consequence o):							
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		IF FEMALE: 23b. Was decedent pregnant in t	ho 🗆	outcome of preg						23d. Date o		
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been signed by the should be detached				.					24a. Was			opsy findings available
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his certif director,	Be	25. Was case referred to medical examiner?	11	Inpatient 2	ER/Outpatient		Other ₄	th (Check on Nursing		Residence 6	✓ Other	Scene
After this funeral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of In		ury at Wo	ork? 2	8d. Describe	how injury occur	red	
eath. tor: A the fu	atio		ding FOUNI estigation Oct 29,	h, Day,Year) D: 2012	FOUND: 2345 hrs	1	Yes 2	V No □	ree tell into	o home strik	ing suc	ject
after d Direction by	Certification:	3 Suicide 6 Cou	ld not be 28e. Pla	ce of Injury - At h		t, factory, office	building,		or Town S	tate)		ral Route Number, City
within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		29a Certifier		Single Far					725 Suitt Dri	ve, Pasadena		
in 24 he Fu pletely	Medical	(Check only	Physician: To the be aminer:On the basis	of examination a								
	Med	29b. Signature and title of certifi	and manner er	stated.		29c. Licer	se numb	er		29d. Date sign	ned (Mor	oth, Day, Year)
To t		0 111				0.0	.M.E.			October 3	1 2012	
with To t		N-W-	*			1				0 0.000	1, 2012	
To t		30. Name and address of perso		use of death (Item								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Ella Louise Dickerson-Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince Hospital Laure George Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours (Month, Day, Year) Director 578-46-0389 1 🗆 M 2 🗶 F October 23, 1934 78 DC show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitied at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Prince George's Lanham 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9404 Franklin Avenue 20706 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Black Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Inspector Dept. of Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Robert Smith Evelyn Locke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J.C. Brown/Husbend 9404 Franklin Avenue, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery November 3, 2012 Suitland, MD 21. Signature of Funeral S 22. Name and Address of Facility Cedar Hill Funeral Home, Inc 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Đứt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 2 Months Septicemia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner -2 months neumonid Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 Unknown been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease, Deep Venous Thrombosis, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown End-Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? Hemodialysis Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 10 Hospital Other: 2 X No 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After to a in by the funera Certificate: 1 X Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

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29b. Sign

ire and title of certifier

Registrar DHMH 17 Rev 06-2011 TEN DING

PATSICIAN

Laurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baako, M.D.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Regional Hospita

29c. License number

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Catherine Duckworth November 2012 9:45 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 11, 1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Mt. Savage, MD. 218-24-8360 82 1 . M 2 . **Director** Usual Residence of Decedent and Mental Hygiene.
Is marked other then "natural", or items 23a or 28e-f show
Is marked other then "natural", or items 23a or 28e-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🕱 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married \$ Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools 12 06 Reading Specialist Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matthew Timothy Campbell Mary Veronica Lyons be 2012 Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Kathy Seymour 1303 Summer Sweet Lane Mt.Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Star Harrford County Friday, Nov.02,2012 cemetery, crematory or other place)
Evans Funeral Chapel and
Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State NOVEMBER Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service (censes Deffrey L.Cair, Sr. CFSP 22, Name and Address of Facility.

Peaceful Alternatives Funeral and Cremetion Center, P.A.

23.5 York Road Timonium, Maryland 21093-2215 Part. En. r m (d) ase, or com (lc) tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart of ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): After this certificate has been signed by the ettending physicien and inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 MARY DUCKWORTH IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 No ours after death.

erei Director: After this certifica
filled in by the funeral director, Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funerei C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and fitte of 29d. Date signed (Month, Day, Year) 2012

State Registrar TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

s of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signaty

_CRNP

JACKIE- JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 24 Physician/ Ronald Tyrone Draper 2°ear | 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Baltimore Haspital Baltimore City 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 205-56-6640 **Director** 1 ▼ M 2 □ F 43Yrs 1-20-1969 Rouald Drage er then "nature!", or items 23e or 28a-f show the Medical Evanniner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No MD**Baltimpre** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3051 Spaulding Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Sp (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be flied within 7. Department of Health end Mental Hyglene. Important: If item 27 is marked other then any injury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Dietician Sinai Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Flood Rosa Draper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Draper/mother 3051 Spaulding Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other pla 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 11-3-2012 Pikesville, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Fun Service Live Wylie Funeral Home P.A. of Balto. Co. 9200 LIberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Severe 2 WOLKS Physician - diabetic disease or condition resulting in death) Medical Examiner Sequentially list conditions, any acting to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine anding physician and use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ettending properties for use as IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? ᇫ acute respiratory 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed acute renal failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? CHOOCIDOSIS performed Yes 2 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director, 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manuar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Kristine 31. Date filed (Month, Day, Year) State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ctoper Frank J. Drega Medical Facility Name (if not institution, give street and number or Location of Death 4c. County of Death Examiner mas 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country) 216-20-8386 Director 1 **X** M 2 □ F Yrs 86 5/10/26 Maryland Usual Residence of Dece Page 1 and 2 should be filed within remander 1 feath and Mental Hygiane. Them of Health and Mental Hygiane. Them 27 is marked other than "natural", or items 23a or 28a-f show reart: If item 27 is marked other than "natural", or items 23a or 28a-f show reart: If item 27 is marked other than "Andical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5910 Oakland Road 21227 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 ★ Yes 2 □ No
If Yes, Give 1 0 Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 1943-46 White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Turbine Room Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Drega Katherine Wojcik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria A. Howell (Daughter) 11 Brucester Bridge Ct. Catonsville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1 Dapartment of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 4 Donation 5 Other (Specify) 10/29/12 Baltimore, Maryland Signature of Funeral Service Lide 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or shock, or reart failure. List of Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Priysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be datached for use as the burial-transit requires that the daath cartificate be executed Cause (Disease or injury ears that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Méspital or Attending Physician: Tha law i within 24 hours after death.

To tha Funeral Director: After this certificate has £ completaly filled in by the funeral director, page 2 si perform 1 🗆 Yes 2 🗆 No 25. Was case referred to medical. 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge death accurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature

State Registrar (than 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CICHELBERGET 5,10 P OV Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Gwynn Oak Baltimore Social Security Numbe Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Min. 214-26-5846 Director 1 🗆 M 2 🗶 F 83 19, 1929 Maryland Usual Residence of Decedent Aug. 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland N/A Baltimore City 1 X Yes 2 No 10e, Street and Number 9 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 6811 Campfield Road 21201 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. δ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Home Maker Own Home of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Riley Margaret A. Furst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Roger Eichelberger / Husband 137 Cherrydell Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/02/2012 Baltimore, Maryland Signature of Funeral Service Licensee Alvson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HTHEROSCLEROTIL Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Pregnant at time of death Other (specify) Day Year been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes No 2 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for the cause of the time, date and place, and due to the cause of mind due to the cause (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year,

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 2 20

30 M

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ASNEEM CAICHAMI, MD P. D. BOX 1525 OWINGS

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month tober 30 : 25 PM Physician/ Michael Eugene Fawley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Health Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
Jun 17, 1956 Hours Director 220-64-1544 1 X M 2 🗆 F 56 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ms 23a or 28a-f sho must be notified at Director 1 Yes 2 XNo MD Washington Boonsboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20649 Benevola Church Road 21713 USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 Xho
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married b 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: 3 Widowed 4 X Divorced White Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Eugene Fawley Margaret Pearson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12936 Yellow Jacket Rd. Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Becky Main/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 11/02/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X remation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final METOSTETIC Non-small Conce Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** -CBS TRUCT 055 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEVINOSIS 120011c 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death. Funeral Director, After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ္ 1 Impatient 2 I ER/Outpatient 3 I DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the I only one)

Registrar

32. Registrar's Sinature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel

29b. Signature and title of certifier

rancisco

29c. License number 400611

MeriTUS Medical

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 OCTOBER AMELIA MARIE FORD 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE NA 308 DREW STREET Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) FEB. 2,1925 Days Hours Country) Director MD 214-20-5823 1 M 2 TYF 87 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If Item 27 is marked other than "netural", or items 23a or 28a-f sho th and Mental Hygiene. 27 is marked other than "netural", or items 23a or 28a-f shov treumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1√ Yes 2 No BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21224 USA 308 DREW STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 √ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RESTAURANT WAITRESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CARMINUCCI JOHN DEANGELIS NAZZARENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 CORNWALL ST BALTIMORE, MD 21224 HELEN KELLY-DAUGHTER Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Depertment of H
Important: If Ite
eny Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 10/31/12 BALTIMORE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON Signature of Funeral Service Licenses 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Acciden3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in manning data. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa

DHMH 17 Rev 06-2011

Registrar

13

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCTUSO 28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCTOBER 26,2012 CATHERINE FRAZIER 9:15 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5969 JESTER ROAD CAROLINE FEDERALSBURG 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 220-14-5320 Usual Residence of Dec 1 □ M 2 🔀 F Yrs 1 - 18 - 1915VIRGINIA Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mechoal Evaniner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 7 No **FEDERALSBURG** CAROLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21632 5969 JESTER ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 WHITE If Yes, Give 1 ☐ Yes 2 🛣 No Specify. Specify. Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER BUILDING Be permit. Page 1 and 2 should be filed Department of Heelth end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY E. PETTEY MILTON A. ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4404 CROSS BROOK DRIVE PERRY HALL, MD.21128 GRANDDAUGHTER DEBRA ZINK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-3-2012 BALTIMORE, MD. LORRAINE PARK 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Euneral Service Lice NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part . Enter the disease, or complications that causer the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) arowa Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-trans P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autons 1 Yes 2 No 2 - No 1 🗌 Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funerel Director: After this certifics erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b. Per FH C933 11/15/2012 III amend #20b Per Maryland? Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2012 Physician/ 3:55 P M Mary Elizabeth Ferris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 918 Grandin Avenue Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-30-1364 Director 1 🗆 M 2 💢 F 89 New York May 2, 1923 r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20850 United States 918 Grandin Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 ia marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) University Student Account Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Caroline Mildred Warner Richard B. Ferris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6224 White Oak Drive, Frederick, Maryland 21701 Health Judy Marple /Niece permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State matory or other place) November 1 M Burial 2 Cremation 3 Removal from State Adelphi, Maryland George Washington Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01305 Dunio Partyl. Eulter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Chronic Obstructive Pulmonary Disease Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
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DHMH 17 Rev 06-2011

State

Registrar

Meenakshi Andrew, D.O.

NOV 0 2

31. Date filed (Month, Day, Year)

10215 Fernwood Road, Suite 100, Bethesda, Maryland 20817

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10:41

Birthplace (State or Foreign Country)

PENNSYLVANIA

20002

Approximate Interval Between

et and Death

leers

Year

2017

10d. Inside City Limits

1 Yes 2 □ No

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral State Registrar

Division

DHMH 17 Rev 06-2011

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier only one) 29b. Signature and title of certifier

CHARLES

31. Date filed (Month, Day, Year)

NOV 0 2 2012

5 Pending

Investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARESH MD

6 Could not be

Certificate:

Medical

9701 VEIRS DRIVE ROCKVILLE, MD.

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28c. Injury at

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

20850

Location (Street and Number or Rural Route Number, City or Town, State)

			For State	State of Maryl				nd Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of l	Jeath	2. Date of De	Reg. No	7111	3. Time of Death
П	Physicia		Franklyn Gey	Greene				Month Nov.	atn 1 ^{Da}	20 1 2	10:30 A M
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location of I		\neg	. County of Deat	
تمديوا	<i>)</i>		Stella Maris			Timon:				Baltim	ore
	Funeral Director		5. Social Security Number 6. Sex 219–56–5498		rs. last birthday)	if Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da			thplace (State or Foreign untry)
			Usual Residence of Decedent	м 2 □ ғ 6	1 Yrs.			May 20,	195	1 Ma	ryland
	ehov	호	10a. State 10b. County	10c.	City, Town or Loc	cation					10d. Inside City Limits
	Mary 28a-i	Director	MD Frederi	ck	Fre	derick					1 🗆 Yes 2 🔀 No
	th the	ral	10e. Street and Number			10f. Zip Code	702			tizen of What Co	
	ath w	Funeral	4711 Biggswood Cou	1 <u>たし</u> 12. Was Decedent Ever in	U.S. 13. V		703 Iispanic Origin	n? (Specify Yes or No-	Ur	nited St	
9	within 72 hours efter death with the Maryland glane. er than "natural", or iteme 23a or 28a-f eho er than "naturalled at the Medical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	11	f Yes, specify Cub	an, Mexican, F	Puerto Rican, etc.)		Black, White	
203	ural",	Completed by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates.		Yes 2 🕅 No	Specify:			Specify: Wh	nite
15-(72 hor	nple	15. Decedent's Edu (Specify only highest grad		(Give I	lent's Usual Occup kind of work done O NOT use retired	during most o	f working	16b. K	ind of Business	Industry
12	/ithin lane. r thar	ပ္ပြ	Elementary/Secondary (0-12)	College (1-4 or 5+)	- 1	N/A	'			N/A	
þ	ge 1 and 2 should ba filed within 72 hours efter death with the Maryland nt of Health and Mantal Hyglane. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other treumatic event, ite Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)			•	18. Mother's	s Name (First, Middle,	Maiden		
ylar	d ba Manta	잍	Franklyn Smith	Greene			Fra	nces Gey			
Jar	shou and ie m	П	19a. Informant's Name/Relationship (Typ			•		or Rural Route Numbe			
e, P	end 2 Health em 27 ther tr	П	Bradley W. Greene 20a. Method of Disposition		b. Place of Dispo		d Court	Frederic Date		Marylano ocation - City or	
nor	ege 1 ant of It: If It y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ F	Removal from State	cemetery, cren	natory or other pla				•	, Maryland
Baltimore, Maryland 21215-0036	permit. Pege 1 Department of Importent: If if eny Injury or c		21. Signature of Functor Service License	Stephanie C	ustor 22			Cremation			
m	Depar Impor		Diff (1)	Septiante C	29	9 Freder	ick Roa	ad, Catons	vi11	e, Mary	land 21228
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cations that caused the cause on each line.	leath. Do not ente	er the mode of dyin	ng, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between
	Pnysician/	18	Immediate Cause (Final disease or condition	BLADDER CA	NCER						Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					1	
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):					_	
	d d ansit	amlu	cause. Enter Underlying Cause (Disease or injury							9	
	be executed sician and i burial-transi	dical Exami	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
9	할 수 없			1							
687	entifice ding pt	Physician/Me	IF FEMALE:	3c. If yes, outcome of pre	eonancv						
Box	atten for u	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	Day Year
_	tha de by tha ached	hys	9 Unknown	9 Unknown					\perp		
P.0	Physicien: The law raquires that tha deeth certifice this certificate has been signed by tha attending pi rai director, page 2 should ba datached for usa as i		Part II. Other significant conditions cor	tributing to death but no	t resulting in the u	inderlying cause g	iven in Part I.				the cause of death?
ds,	raquires been sig should b	te d	V					_	Yes 2	□ No 3 □ P	robably 4 Unknown
Ö	law ra nasbe a 2 sh	Completed by						24a. Was	DSV	prior to	topsy findings available completion of cause of
æ	t: The		25.11					perfe 1 \sum Yes	2 K N	o 1 🗆 Ye	s 2 🗆 No
/ital	certif	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 😾 No	ospital:	P ☐ ER/Outpatier	Tou	er.	(Check only one)		Wou 6	HOCDICE
of \	Phy er this eral d	은 (원	27. Manner of Death	28a. Date of injury	28b. Time of	28c. Inju	ry at	sing Home 5 Resi 28d. Describe			ify) HOSPICE
O	Attending ar death. ector: After by the fune	lcat	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	r) injury	M 1 🗆	k?]Yes 2 □ N	lo			
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (City or Tox			ral Route Number,
ō	Hoepital or 24 hours afte Funeral Dir trely filled in	calc	29a. Certifier 1 ☐ Certifying Physi	cian: To the best of my ki	nowledge death	occurred at the tim	o date and n	lace, and due to the o	auco(c) a	and manner as s	tatad
	To the Hoepital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.	Medical	(Check 2 Medical Examin		ation and/or invest	tigation, in my opin	ion, death occu	urred at the time, date	and place	e, and due to the	cause(s) and manner stated.
	vithir To the comp	2	29b. Signature and title of certifier	/ 4		29c. Licens				te signed (Mont	
	A .		1 Star	CANT		K14	19797		/	1/1/201	2_
	(0 AM			mpleted cause of death (
	Sta		JACKIE JONES, C. 31. Date filed (Month, Day, Year)	RNP 2300 DI 32 Registrar's Si		ALLEY RD.	TIMO	NIUM, MD 2	2109:	3	
	Registr		MOV 0 2 201			Kel					

10:30 a.m.

NOVEMBER 1, 2012

FRANKLYN GREENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/26 /2012 John Kenneth Greenwell 1:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gwynn Oak Baltimore 6000 Central Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) **Director** 216-34-6052 1 XM 2 □ F 75 2/10/1937 MD Usual Residence of Deced or 28a-f sho 10a, State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Gwynn Oak Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 6000 Central Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2102,22 Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Instrument Mechanic Domino Sugar 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Page 1 and 2 should be David Greenwell Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryne McGee/Daughter _Arbutus, MD_21227 Taylor Ave., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🛛 Cremation 3 🗆 Removal from State Atlantic Crematory 10/28/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Ave. Catonsville 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami 24 hours after death. Furthis certificate has been signed by the attending physician and Funeral Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Hospital or Attending injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) PV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

NOV 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stacey Gibson-Wo	1	State of Maryland / Department of Health and Mental I -For State Certificate of Death	Hygiene	Reg. No. 201	2 3505
Physician Medical Examine	/ 1 :r	Stacey Sibson-Woods	2. Date of Domestin Month October	eath Day Year : 31, 2012	3. Time of Death 0114 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Sinai Hospital Baltimore	ath	4c. County of Dea	ith
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24h	8. Date of lin.	Birth (MM/DD/YYYY) 9. B	
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Maryland s or 28a-f show any inflied at once. Director	1	MD Saltimore 10f. Zip Code		10g. Citizen of What Co	1 Yes 2 No untry?
ith the Ma 23a or 23 notified		3508 Clifton Avenue 21216 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Ves or	USA 114 Book Amer	origan Indian Plack
10re, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	٦Ľ	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Yes, Give Year or Dates: If Yes, Specify Cuban, Mexican, Puer 1 Yes, Specify: No specify:	to Rican, etc.)	White, etc.	Plack,
5-0036 led within 72 hours Hygiene. I other than "natur the Medical Exam Completed	-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use recommendation of the complete of th		Retai	s/Industry
D 21215-00; should be filed with and Mental Hygiene 7 is marked other that antic event, the Med		Thomas Mills	rt10 (e Maiden Surname)	
re, MD 21 I and 2 should Health and Me Fitem 27 is ma		a. Informant's Name/Relationship (Type, Print) A. Informant's Name/Relationsh	Rural Route N	lumber, City or Town, Star Poul Honore 20c, Location - City of	mo
Baltimore, bernit. Pages I ar Department of Hec Important: If ite	-	20a. Method of Disposition 20b. Place of Disposition (Name of cembery, crematory or other place) 4 Donation 5 Other Specify:	5/201	2 Salem	NS
Baltimo permit. Page Department o Important: injury or oth	2	21 Signature of Poneral Service Licentee 22 Nove and Address of Fall 1902	ene fu	neral Ser 10e (2122)	vices
Physician /Medical		23a. Part I. En <mark>ter t</mark> he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiov			Approximate Interval Between Onset and Death
Examiner	9	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
S led	0 (If any, warfing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			1
0, s be executed sician and burial - transit	-	d. X UNPENDED AMENDED 23a,27,per me,g935 1-14-13 sm			
lox 68760, eath certificate be attending physici for use as the buri	_	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	23d. Date of delive Month	Try Day Year
the death certificate by the attending phy tiched for use as the three for use as the Physician/Me	1	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown			
s, P.O. ires that th signed by d be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 🗆 Y		obably 4 🗸 Unknown
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me			per 1 ✓ Yes	opsy prior to formed? death?	autopsy findings available completion of cause of
Vital Recysician: The his certificate director, page	2	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nurs	k only one) sing Home 5	Residence 6 Oth	er:
ion of Vi tending Physi eath. for: After this the funeral dir	2	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending		e how injury occurred	
Division o 24 hours after death. 24 hours after death. Funeral Director: Aftered filled in by the funeral Certification:		2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location or Town	(Street and Number or R , State)	tural Route Number, City
D To the Hospital within 24 hours To the Funeral completely fille	(100	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place are 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
F iv G	2	29b. Signature and title of certifier 29c, License number O.C.M.E.		29d. Date signed (M October 31, 201	
0	3	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Balti	imore, MD 2	21223	
State	4	31. Date filed (Month, Day, Year) 32. Registrar's Signature	OG:A	To the state of th	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar		aftment of F tificate of L		, ,	- 00	10 05061	
			Registrar 1. Decedent's Name (First, Middle, La.	st)		uncate of L	Jeann	2. Date of Deat		3. Time of Death	
	Physicia Medic		William	Gre	en			Octobe	er 27, 2	012 3:33 A м	
\bigcirc	Examir	er	4a. Facility Name (if not institution, give 100 N. Broadway			4b. City, Town, or Balti	Location of Death		4c. County	of Death NA	
	Funeral Director			ex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09-27-5	Year)	Birthplace (State or Foreign Country) MD	
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation		<u></u>		10d. Inside City Limits	
	Maryla 28a-f ptified	Director	MD NA	Ва	ltimor	е				YYes 2 No	
	with the 23a or 3	Funeral D	10e. Street and Number 100 N. Broadway	Apt.#108		10f. Zip Code 212	231		10g, Citizen of V	vhat Country? USA	
036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Blac	e - American Indian, k, White, etc. African American	
5-0	2 hour "natu	plet	15. Decedent's E (Specify only highest gr			ent's Usual Occupa		na	16b. Kind of Bu	siness/Industry	
21215-0036	within 7; rgiene. her than t, the Me	3 K Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade 1 Yes 2A No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Department of Public W							City of	Baltimore	
land	be filed yelled repeated the filed of the file event,	To Be	17. Father's Name (First, Middle, Last) Thomas	Green			18. Mother's Name Emily	e (First, Middle, N	Maiden Surname Booker		
Maryland	1 and 2 should be file of Health and Mental H item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (1		19b. Mailin	g Address (Street a N. Broads	and Number or Rura	l Route Number, 108 Balt	City or Town, St	tate, Zip Code) 21231 Marvland	
	Page 1 and 2 s ment of Health ant: If item 27 ury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispos emetery, crem	sition (Name of natory or other plac	e) [Date	20c. Location -	City or Town, State	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot once.	_	4 ☐ Donation 5 ☐ Other (Special Street Special Street) Other (Special Special		22.	Cemetery Name and Address	s of Facility W	vlie Fur	Woodla neral Ho	ome P.A.	
	HD = # 0		23a. Part 1. Enter the disease, or com	plications that caused the deat						Maryland 21217	
	Physician/ Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	miè	cardia	myop	nthy	51,	Approximate Interval Between Onset and Death	
	Examiner	ier	Sequentially list conditions, if any, leading to immediate	b. CONOMA Due to (or as a consequence) C. Due to (or as a consequence)	~y ₩	tery c	lisease			years	
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Diab	etes	melle	tus			years	
00	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a consequent of d.	Jence otj:					V	
928	rtificat ing ph e as th	/Med	IF FEMALE:								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mor	e of delivery hth Day Year	
ls, P.O	uires that t n signed b uld be deta	by	Part II. Other significant conditions of	contributing to death but not res Kidney di	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob		bute to the cause of death?	
Division of Vital Records, P.O.	sician: The law req s certificate has bee director, page 2 sho	Completed	Demente	A				24a. Was ar autops perform	p p	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☑ No	
ita	ician: T	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Check	_		2 100 2 22 100	
of V	g Phys er this reral dir	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2	28b. Time of	28c. Injury	4 Nursing Horat	me 5 Reside			
ion	tendin leath. or; Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		injury	M 1 🗆	? Yes 2□No				
28f. Location (Street and Number or Rural Route building, etc. (Specify) 28f. Location (Street and Number or Rural Route building, etc. (Specify)									r or Rural Route Number,		
Properties of the part of the									to the cause(s) and manner stated.		
	To the vithin comp		29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29c. License num								
	3 M		30. Name and address of person who have	completed cause of death (Item	23a) (Type, Pr	int)	V. Chin	yles S.	+ Bo	lts md 212.	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signat		0101	7-00111			7	
	Registra		NOV 0 2 2012	hours A	back	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Physician/ am 0 Medical 1a. Facility Name (il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing Montgomery Rockville Grove If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** oct 21, Year 932 80 Jamaica Director 114-28-0354 1 🗆 M 2 🔀 F Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City. Town or Location 10a. State Examiner must be notified at Director 1 ☐ Yes 2X No Germantown MD Montgomery 10f. Zip Code 10g Citizen of What Country? the 10e. Street and Numbe ò Funeral USA 23a 20874 18003 Mateny Road #406 items (death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African or i 1 Never Married 2 Married þ be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar 3 X Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Dietary Aide 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F မ Naomi Dora Dixon Akeman Sutherland permit, Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 18003 Mateny Road #406 Germantown, MD 20874 19a. Informant's Name/Relationship (Type, Print) Ivy Owen/cousin item 27 other Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of remetery, crematory or other place)
Final Journey Crematory 11/01/12 Department of Important: If it any injury or o o 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign or e of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARREST Immediate Cause (Final ARDIOPULMONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) PERLIPIDEMI Examiner EARC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) the be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 💢 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ✓ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending after death. 2 🗆 No Investigation Could not be the 1 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one e and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 28656

State

DHMH 17 Rev 06-2011

Registrar

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KASSI MUD

MD 20850

Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVI (ASSI MD 15245 SHADY GROVE ROAD, #130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vincent Graas 9:27 John 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Bowie Health Center Bowie Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days 577-56-5639 **Director** 1 X M 2 🗆 F 69 11/20/1942 NY Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director must be notified 1 🗌 Yes 2 🙀 No Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 23a 21114 6815 Crofton Colony Court items? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2🛣 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo If Yes, Give Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Photographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Barbara W. Wysocki Francis J. Graas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sister-21061 Glen Burnie, Maryland Mrs. Carol J. Clark in-law 126 Olen Drive, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Our Lady of the Fields 10/25/2012 Millersville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility $\,1\,$ 2nd $\,Ave$, $\,SW$ Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. M01357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 minutes disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown been signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes To Be Completed 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an cate has l autopsy perform 1 Yes 2 No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manne of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending injury 1 Natural Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License numbe of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 12~ Svite + mb 2000 Hanover PKW1 215 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Steven Kenneth Grossman 11/1112 OHSID AM

		Please Type or Print in		delible Ink. Ensure A artment of Health and N			
	-	For State State Registrar		tificate of Death		eg. No. 2012	2 35064
Physicia Medic	_	1. Decedent's Name (First, Middle, Last) STEVEN G 1055 MAN			2. Date of Deat Month N 5V	Day Year	3. Time of Death 4:56 A M
Examir		4a. Facility Name (if not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Dea Montgom	
Funeral Director			s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 3,	Year) Co	rthplace (State or Foreign ountry) V York
Maryland 28a-f show otified at	tor	10a. State 10b. County 10c.	City, Town or Loc				10d. Inside City Limits
the Mary or 28a-f e notifie	ا≝اا	Maryland Montgomery 10e. Street and Number		10f. Zip Code	1	l 0g. Citizen of What C	1 ☐ Yes 2 X No ountry?
s 23a c nust be	Funeral	14820 Soft Wind Drive		20878		United St	
036 s after death v ral", or items Examiner mu	by	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces 2 1 □ Yes 2 □ No If Yes, Give Year or Dates.		Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	te, etc.
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	(Give F	lent's Usual Occupation kind of work done during most of wor O NOT use retired) ector	king	16b. Kind of Business Substance Program	Abuse
/land 2 d be filed w Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Sol Grossman		Edna	ne (First, Middle, N Mallet		
Mary 2 should th and h 27 is ma		19a. Informant's Name/Relationship (Type, Print) Lana Sandler Grossman, Wife	19b. Mailir 14820	ng Address (Street and Number or Ru Soft Wind Drive	nal Route Number, N. Poto	City or Town, State, ZomaC, MD	20878
Baltimore, Maryland 212 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Innoce.		20a. Method of Disposition 1	b. Place of Dispo cemetery, cren udean Me	sition (Name of natory or other place) morial Gardens 1.	Date L/02/12	20c. Location - City o	
Balti permit. I Departm importa any inju		21. Signature of Fundamental Property of the Control of Fundamental Property of the Control of t	1008 25	reninskysshebrew ! 4 Carroll St., N	uneral H	Home ington, DC	20012
Prysician/	de y	23a. Part 1. finter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	leath. Do not ente	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Due to (or as a cons	equence of):				
B it	Examiner	Sequentially list conditions, Due to or as a consciouse. Enter Underlying	se uence of:				
e executed ian and urial-transit	1-	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution)	equence of):				
68760 ertificate be iding physic	edic	d					
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 L	Ectopic pregnancy Other (specify)		23d. Date of d Month	lelivery Day Year
ords, P.O. Box requires that the death been signed by the atte should be detached for		Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause given in Part I.	23e. Did to	5	to the cause of death?
Division of Vital Records, all or Attending Physician: The law requires s after death. So increased the cortificate has been signed in by the funeral director, page 2 should the control of the funeral director.	Completed by				24a. Was a autop perfor 1 Yes	sy prior to med? death?	autopsy findings available o completion of cause of es 2 \square No
ician: T	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death (Che			
n of Vital Rec	e: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of injury	nt 3 🗆 DOA 4 🗀 Nursing F		ence 6 Other (Spectrose) ow injury occurred	<u></u>
ttendin death. tor: Aft	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	=	M 1 Yes 2 No	28f Location (S	treet and Number or F	Rural Route Number.
Divis Ltal or A rs after al Direc ed in by		4 Homicide determined building, etc. (Spe	ecify)		City or Tow	n, State)	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my king the desired from the basis of examiner: On the basis of examiners on the basis of examiners. To the basis of examiners on the basis of examiners on the basis of examiners.	ation and/or inves	stigation, in my opinion, death occurred	at the time, date at	nd place, and due to the	e cause(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
		30. Name and address of person who completed cause of death (Item 23a) (Type,	9 C(8+3	D. = i	11/1/12	
7		Drutt V. Boccin mg 64	1= 140046	woods 12 #665	BETIA	BOA MI	7 20817
Sta Regist		31. Date filed (Month, Day, Year) NOV 0 2 2012	A. Spar	Kel			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:54art Violet. Grusky 10/18/2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Yea 7/24/15 Birthplace (State or Foreign Country) 1 Year I If Under 24 Hrs. Age (In yrs. last birthday) If Under Funeral Days Min. Hours 128-01-9173 97 1 🗆 M 2XXX Director NY Yrs. Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 X No DE Sussex Lewes 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number must be 1 Funeral 23a 23400 Boatsman 19958 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Armed Forces?

1 Yes 2 No Black White etc. 5 1 Never Married 2 Married 2 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates "natural", Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Translater Greenpoint Hosp. traumatic event, the 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Page 1 and 2 should be file ment of Health and Mental I ပ္ Paul Barowski Helen Murawski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DE 19958 23400 Boatsman Ct. Lewes Department of Health a Important: If item 27 is any injury or other trai Paul Grausky Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Long Island National Cem. 10/24/2012 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 Cremation 3 A Removal from State Pinelawn NY 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine and I-transit death certificate be executed resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by met sition 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Anazazca To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural iniury 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar Wike

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DCMonth Physician/ 0755 AM KATIE G. GREEN 21812 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) CENTER **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 F **Funeral** 6 18 17 19 4 8 NORTH CAROLINA 238-84-7030 64 Director Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 28a-f shov 10a. State MD Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? the 10e Street and Number Funeral UNITED STATES 2633 CHESTERFIELD AVE 21213 death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black White etc Specify: BLACK 1 Never Married 2 Married þ 1 ☐ Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOME PRIVATE 127 is marked other or traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEROY HOPKINS EULA MAE ROGERS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWARD GREEN/HUSBAND 2633 CHESTERFIELD AVE., BALTIMORE, MD.21213 Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11/1/12 OWINGS MILL, MD 22. Name and Address of Facilit CAPITOL MORTUARY 425 MARYLAND AVE NE WASHINGTON, DC 20002 21. Signat #e of Funeral Service L. ensee Emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Approximate Onset and Death Immediate Cause (Final DIFFUSE ALVEOLAR HEMORRHAGE Physician/ disease or condition resulting in death) Medical nsequence of): SCLAROSING CHOLANGITIS **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician ar Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death?
1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛚 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မှ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

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h (Item 23a) (Type, Print) GREENE ST., BALTIMORE, MARYLAND 21201 backs

d cause of dea SOUTH

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OCTOBER 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DCTOBER. ^{Day}4 2012 0115 ANTHONY GRAHAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 6 127765 579-82-7329 47 Yrs. WASHINGTON DO Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 X Yes 2 No DC WASHINGTON 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 333 36th St., S.E. 20002 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 √ Yes 2 □ No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:BLACK 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CLIFTON HARTRIDGE VERDELL GRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TYRONE E. GRAHAM/BROTHER 2523 PALMER PL. S.E. WASHINGTON, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) <u>HESAPEAKE</u> 10/27/ 12 BELTSVILLE, MD e of Funeral Service 22. Name and Address of Facility CAPITOL MORTUARY Signati 1425 MARYLAND AVE NE WASH r complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERTENSIVE CRISIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MORBID OBESITY Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last AICD Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has to the Funeral Director. After this certificate has to the funeral director, page 2.3. autopsy performed? Yes 2 No 1 Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Investigation ☐ Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State

DOUGLAS

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Registrar

HOSPITAL

DR.

CHEVERLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYO

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTO be Physician/ 8:15AM Eugene Hilton - Bev Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Levindale f Under 1 Year If Under 24 Hrs fonths Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Numbe Country **Funeral** Months 10727/19237 89 220-18-4100 Director Usual Residence of Deceden Show 10d. Inside City Limits 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 ☐ Yes 2 X No MD. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21117 9773 Groffs Mill Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Be Completed by SpecifiAfrican -American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Govans Presbyterian Church Sexton UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Amanda Bennett Elliott Hilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9021 Meadow Heights Road, Randallstown, Maryland 21133 Jessie McNair / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/9/2012 Baltimore, Maryland Mt. Zion Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licersee 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760x as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the aid d be detached for 9 Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has page 2 s 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner' 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 24 hours after death.
Funeral Director: After this leted filled in by the funeral dir Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29d. Date signed (Month, Day, Year) 29b. Signa 21215

State Registrar

Hilton-Bes

Baltimore MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH G933 11/02/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 700 2012 M an Medical 4a. Facility Name (if not institution, give street and n City, Town, or Location of Dea 4c. County of Death **Examiner** NIA General rapy/and Baltimore Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** Min Hours 1 M 2 F Director MAY 27 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 28a-f les 2 No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be r by Funeral Park Lake DR. Apt. 91 21217 1154 items Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Forces Black, White, etc. If Yes, Give "natural", or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Yes 2 No Specify: lack 3 Widowed 4 ☐ Divorced Completed and Mental Hygiene.
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aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chacke Haplani iruckina Driver Be 18. Mother's Name (First, Middle, Maiden Surname Father's Name (First, Middle ဂ္ permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. *darland* City or Town, State, Zip Code) Mailing Address (Street and Number or Rural Route Number, Apt. C Annapolis MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispos 20c. Location - City or Town, State 1 Burial 2 Cremation 3 - Removal from State Catonsville, mo metro Cremator 4 Donation 5 Other (Specify 21. Signature of Funeral Service Liver 70 Fredhillen Pass Balto. MD 21229 23a. 1 Feet the disease, or complications that caused the death. Do not enter the short, in heart failure. List only one cause on each line. Interval Between Onset and Death Immedi te Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran attending physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day been signed by the a should be detached Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 W Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page 2 death?
1 Yes 2 No certificate 25. Was case referred to medical director. 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Medical Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 No Accident Investigation Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and Ale of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10/34 30. Name and address of person who completed cause of death (Item 23a) (Type MORY lana 31. Date filed (Month, Day, Year, State NOV 0 Registrar

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			Registrar 1. Decedent's Name (First, Middle, La	st)			inouto or E		2. Date	of Death			3. Time of Death
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	arylar la-f sl ified	ectc	MD Montg	omery		5	Silver Sp	ring					1 ☐ Yes 2XX No
	or 28 e not	늅	10e. Street and Number				10f. Zip Code			100	g. Citizen o	f What Cour	ntry?
	with s 23a ust b	Funeral Director	2601 Bel Pre Rd	•				0906			Unit	ed St	ates
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer		0		2. Name and Addre app Fune 33 Gist				Servi	ces	910
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Ö.	at the		Part II. Other significant conditions	contributing to death b	out not res	ulting in the	underlying cause g	iven in Part I.	23e	. Did toba	cco use co	ontribute to	the cause of death?
S, F	ires ti signo	d by	DYSPHAGIA							1 \square Yes	2 N	o 3 🗆 Pr	obably 4 \(\Bigcup \text{Unknown} \)
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Division of Vital Records, P.O.	or Attending Physician: The law requires that the death certifi- ifter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	be 28e Place of Init			reet, factory, office		28f. Loc City	ation (Stre or Town,	eet and Nui State)	mber or Rur	al Route Number,
۵	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Pl	nysician: To the best of	my know	ledge, death	occured at the tim	e, date and place	, and due to	the caus	e(s) and ma	anner as sta	ted. cause(s) and manner stated.
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	Sta Regist	ite	only one) 3 Certifying N 29b. Signature and title of certifier Fathm A 30. Name and address of person wh FATIMA A 31. Date filed (Month, Day, Year)	32. Registr	ar's Sign	ture for	Rad						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3507 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 29, 2012 Walter Harris Hershey 1830 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Jun 7, 1924 Maryland Director 88 217-12-5996 1 **X** M 2 □ F Usual Residence of Deced ir then "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Ves 2 No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 20878 8 Red Kiln Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Manital Status Armed Forces? Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1941–43 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
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Final Journey Crematory 11/01/12 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signatore of Funeral Service Licensee MO1251 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ e0515 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner gestive Failure Heart Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (r as a consequence of) Examine ettending physicien and for usa as the burlei-transit Pneumoni Due to (or as a consequence of): resulting in death) Last Physician/Medical ershey, Walter Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death ☐ Yes 2 ☐ No After this certificata hes been signad by the functional director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Difficile Colitis 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 잍 24 hours after deeth.
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi only one) saul wo 29c. License number 29d. Date signed (Month, Day, Year) 10 2012 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctor's Drive Germantown 32. Registrar's Signat State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_1	For State Registrar		Cei	rtificate of D	Death		Reg. No.	112	35072
	Physicia		1. Decedent's Name (First, Middle, Las John B. Hoffman					2. Date of De Month Octobe	Day	Year 2012	3. Time of Death 12:45 A ^M
	Medic Examin	_	John B. Hoffman 4a. Facility Name (if not institution, give				Location of Death		4c. Count	ty of Death	
			8201 Langport Ter			Gaithers If Under 1 Year	sburg If Under 24 Hrs.	La Data of Bir		gomer	y place (State or Foreign
	Funeral Director		5. Social Security Number 6. S 236–74–1820 Usual Residence of Decedent		rs. last birthday) 63 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jan 1,	y, Year)	Coun	
	land show	tor	10a. State 10b. County		. City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2X No
	e Mary	Director	Maryland Montgon 10e. Street and Number	nery Ga	ithersbu	10f. Zip Code			10g. Citizen o	f What Cou	
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at.	Funeral I	8201 Langport Ter			20877			USA		
	r death		11. Marital Status 1 ☐ Never Married 2 【 Married	12. Was Decedent Ever in Armed Forces? 1 K Yes 2 No	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No Rican, etc.)	ВІ	ace - Amerio lack, White,	etc.
980	rs after ral", c	ed by	3 Widowed 4 Divorced	KV- Cite	69-70	1 ☐ Yes 2 ☐xNo	Specify:		Speci	Whit	e
5-0	72 hour	Be Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup	ation during most of wor	king	16b. Kind of	Business/In	dustry
72	vithin 7 iene. rr than	S	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired)							pply
pu	filed v al Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan		, Maiden Surna	me)	
yla	ould be fill od Mental marked o	욘	Bernard Hoffman	For Dist	10, 11, 7	ing Address (Street	Doris Re		or City or Town	State Zin	Codel
Maryland 21215-0036	d 2 should alth and Me 27 is marl or traumati		Joan Hoffman/wife		8201	Langport	Terrace	Gaithe	ersburg,	, MD 2	0877
Baltimore,	Page 1 and nent of Heal int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Ob. Place of Disp cemetery, cre Final Jo	osition (Name of ematory or other place urney Cre	∞) matory 11	Date 1/03/12	20c. Location Woodbi	,	
Balti	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Liver)1251_B	2. Name and Addre Oing Home everly L.	crematic Heckrott	on Servi	ice P.(Clarks). Box	x 784 e, MD 21029
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the							Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition resulting in death)	a. Colon Cano						_	Onset and Death 3 months
-	Medical Examiner		resulting in doubly	Due to (or as a cor	isequence oi):						
	D #	niner	Sequentially list conditions, if any, leading to immediate have Enter Underlying	Due to (or as a cor	nsequence of):						
	xecuter and al-trans	Aedical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):						
9	te be e nysiciai he buri	dical		■ d							
68760	ertifica Iding ph		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d.	Date of deli	very
. Box 68	Attanding Physician: The law requires that the death certificate be executed or death. setor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at tim	e of death 5	Other (specify)				Month	Day Year
s, P.O.	ires that t signed b Id be deta	<u>≨</u>	Part II. Other significant conditions Diabetes	contributing to death but ne	ot resulting in the	underlying cause g	iven in Part I.				the cause of death?
ord	w require ts been si 2 should I	Completed						24a. Wa	opsy	prior to c	opsy findings available ompletion of cause of
Rec	sician: The law certificate has l lirector, page 2 s	S						1 ☐ Ye	formed? s 2 XN o	death?	2 🗆 No
ital	sician: certific irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 [] FD/0.++i	Ot	Place of Death (Che		sidence 6 🗆 0	Other (Speci	
of V	ng Phys ter this neral di	te: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	2 ER/Outpati 28b. Time ear) injury	of 28c. Inju	ıry at rk?		how injury occ		77
Division of Vital Records,	I or Attendir after death. Director; Af I in by the fu	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury -	At home, farm, s]Yes 2 ☐ No		(Street and Nur	mber or Rui	al Route Number,
Ö	urs afte ral Dire	Se		building, etc. (S		المام المام المام المام المام المام المام المام المام المام المام المام المام المام المام المام المام المام الم	no data and place			anner as st	ated
	To the Hospital or Atte within 24 hours after de To the Funeral Director completely filled in by the	Medical	(Charle 2 Modical Eva	mysician: To the best of my miner: On the basis of exam urse Practitioner: To the be	ination and/or inve	estigation in my oper	nion, death occurred	l at the time, dat	e and place, and	due to the c	ause(s) and manner stated.
	To the To the comp		29b. Signature and title of certifier	1 ()			se number	Ca	29d. Date sig		
	, la		30 Name and address of names with	o completed cause of don't	(Item 23a) (Type		1) 7310			131/1	L
	010)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 300, Shannon O'Connor, M.D. 9707 Medical Center Dr. Rockville, MD 20850								
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature A.	KN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral P1110008m Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2012 October Physician/ 14:45 M JAMES HORCHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 216-30-9772 Director 1 **X** M 2 □ F 78 8-10-1934 **MARYLAND** 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director must be notified 1 Yes 2 No or 28a-f MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1402 BONNETT PLACE 21015 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗙 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify. WHITE Specify "natural", 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MECHANCIAL other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH DRAFTSMEN ENGENEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HENRY HORCHER JOSEPHINE DOYAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traunonce. DOROTHY J. HORCHER **SPOUSE** 1402 BONNETT PLACE BEL AIR, MD, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burjel 2 Cremation 3 Removal from State ST. STANISLAUS 11-2-2012 BALTIMORE, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 21. Signature of Funeral 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 0 Immediate Cause (Final Ph. i i n disease or condition Medical resulting in death) 12 hours **Examiner** RUHONIA ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last nding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş. 1 Yes 2 No 3 Probably 4 Unknown ORation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours af To the Funeral Discompletely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and titl 29c. License number 29d Date signed (Month, Day, Year son who completed cause of death (Item 23a) (Type, Print) FE MOMASON 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARFELD Doris 9:05 A October 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Country)
Washington, DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) Funeral 73 1 🗆 M 2 🗓 F Director 578-52-2302 May 19, 1939 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. The strength and Mental Hyglene item 27 is marked other than "natural", or items 23a or 28a-f should other traumatic event, The Modical Examinar must be notified at 10a. State Director 1 Yes 2 No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20815 3210 Woodbine Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ¥☐ No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker/Artist Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sadie Berger Milton Buckner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1661 Crescent Place, NW, #101, Washington, DC 20009 Amy Harfeld, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/04/12 permit, Page 1 e Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 X Removal from State Sir Moses Montefiore Cemetery Richmond, VA 4 Donation 5 Other (Specify) Tareninskysslebmew Funeral Home 21. Si mature o Funeral Service Licenson 20012 100x254 Carroll St., NW, Washington, DC 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine day, leading to immediate cause. Enter Underlying Cause (Disease or injury Sibl • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician end etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Ulmonar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? extremity osteomyelit15 24a. Was an lower autopsy 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 REN/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0062435 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive Rockville 20850 ElsayyaA ayed 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 food Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 11:20 A M Physician/ October Letitia B. Hollensteiner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Sunrise at Fox Hill 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F Days Hours February 9, 1926 Nebraska 507-22-0311 86 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State Director 1 X Yes 2 No Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō must be Funeral 23a 20008 United States 2339 Massachusetts Avenue, N.W. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Black, White, etc. 20 1 Never Married 2 X Married Completed by 1 🗌 Yes 2 💢 No Specify: Baltimore, Maryland 21215-0036 White 'natural" 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Self-Employed permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene, Important: If item 27 is marked other that any injury or other traumatic event, the lonce. Author Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginna Connell 2 H. Malcolm Baldrige 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7710 Radnor Road, Bethesda, Maryland 20817 MalcolmHollensteiner / Son 20b. Place of Disposition (Name of Montgomery or other place) Crematorium, Inc. 20c. Location - City or Town, State November 1, 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2012 Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Signature Fune al Savice Licensee 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Cardio Pulmonary Arrest Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Physical Debility Sequentially list conditions Dualto for as a consequence off if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Peripheral Vascular Disease attending physician and for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the first of the funeral Director. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 🗌 Yes Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 🛛 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death iniury work? 1 X Natural 5 Pending Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 31, 2012 D63232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Gomez, M.D. 15245 Shady Grove Road, Rockville, Maryland 20850 State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maya Marie Jackson 2012 12:09 OM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SQUARE MEDICAL BALTIMORE FRANKUN CENTER ROSEDALE If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director None 1 M 2X F Oct. 20, 2012 Maryland ed other than "neturel", or items 23a or 28e-f show event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits death with the Meryland Directo 1 Yes 2 XNo Harford Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3314 Shrewsbury Road 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 ☐ Married Page 1 and 2 should be filed within 72 hours efter or ment of Health and Mental Hyglene. ant: If Item 27 Is marked other than "neturel", or ģ timore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Kevin Jackson Chanene Latrice Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michael Jackson / Father 3314 Shrewsbury Road, Abingdon, Maryland 21009 Department of Health Important: If Item 27 any Injury or other treated. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rose Hill Svcs. LLC 10/25/2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility gessee Liveave 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Pπysician/ PREMATURE RUPTURE OF MEMBRANES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the deeth certifica within 24 hours after death.

To the Funerai Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use est IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: ဨ 1 🗌 Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064601 10/21/12 Marlaga 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

LEIGH

0 VON

31. Date filed (Month, Day, Year)

MAT

FRANK

9000

32. Registra s Signature

SQUARE DR.

BALTIMORE MO ZIZ37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Melvin 1:36 AM Junes 2012 Medical 4a Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maryland Medical N/A of If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Funeral 9. Birthplace (State or Foreign Hours Min 1 M 2 D F Country) Director 213-84-1142 May 28, 1965 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD **Baltimore City** 1 X Yes 2 □ No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 908 Bevan Street 21230 U.S.A. items ; within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married ò þ Maryland 21215-0036 1 Yes 2 No Specify Black If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) Cook **Sunset Restaurant** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Melvin L. Jones Carolyn White . Page 1 and 2 should be ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Jones 908 Bevan Street Baltimore, MD 21230 Baltimore, 20a. Method of Disposition ,20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department o injury or Oct 26, 2012 Catonsville, Maryland Metro Crematory, Inc. Donation 5 Other (Specify) 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 21217 anyi 23a. Part 1. Enter the disease, or complications that cause shock or heart failure. List only one cause on each line or complications that caused the deat Approximate shock or heart failu Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) **≱** Medical Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hepatitis Completed 1 Yes 2 No 3 Probably 4 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? has performe Yes 2 No 1 Yes 2 🗌 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 24 hours after death Funeral Director: A 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 033485719 2012 ss of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death October 2010 Physician/ ROBERT OTTO JENSEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death och Raven Community 14109 enter BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 1-7-1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours MARYLAND Director 1 ▼ M 2 □ F 214-46-8306 68 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at with the Maryland Director **PARKVILLE** MD. BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10 NEVES COURT 21234 TISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "naturel", or Completed by 1 Never Married 2 X Married 1 XYes 2 □ No If Yes, Give Year or Dates. 1969–197 Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne eny injury or other treumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NATIONAL Elementary/Secondary (0-12) College (1-4 or 5+) INSTRUMENT MACHINIST æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT O. JENSEN MARIAN DOUB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARKVILLE, MD. 21234 **SPOUSE** 10 NEVES COURT JERRILYN JENSEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ATLANTIC CREMATORY 10-29-2012 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) SCHIMUNEK FUNERAL HOME, INC. Ignature V Funeral Se ce License 22. Name and Address of Facility 9705 BELATR ROAD NOTTINGHAM. Rart 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final a ancev 0 on Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burlal-transit Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending physical for use as the b IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Year sate has been signed by the a page 2 should be detached for 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate the completely filled in by the funeral director, page 1 Yes 2 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSPICE Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of deat Kaven Bouleyavo 1016 5e0Vge avyland 31. Date filed (Month State Registrar

DHMH 17 Rev 06-2011

Robert

Jensen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deat Physician/ Day Month ONNTOY 200 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death dy OW ONZO erer 9. Birthplace (State or Foreign Country) NY Social Security Number If Under 24 Hrs. . Age (In yrs. last birthday, If Under 1 Year 8. Date of Rirth **Funeral** Months Days Min Oct 15 213-36-1269 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Howard Ellicott City 1 Yes 2 XNo 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9006 Overhill Drive 21042-5221 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 01. 1 Never Married 2 XMarried Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) State of Maryland College (1-4 or 5+) bank examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Edwin Theodore Johnson Sr. Agnes Jacobsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Glenda K. Johnson (spouse) Health 9006 Overhill Dr., Ellicott City, MD 21042-5221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 10-31-12 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel 'n Dage Harget Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or impury that initiated events Due to (o s a consequence of ZV Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □ Unknown Records, 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 0P 5((0 autopsy or Attending Physician: The Yes 2 1 Yes Division of Vital 25. Was case referred to medical B funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural Accident 5 Pending work nours after death.

neral Director: Aft
dilled in by the fur 1 Yes 2 No Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur d title of certifier 29d. Date signed (Month, Day, Year) F007 2012 dress of person who co 5755 Codar Ln, Columbia, Md 21044 2 D.O. 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12, per fh, g935 1-2-13 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 29 Day 2012 Year Leonard Paul Jensen 4:57 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Country) unk 482-64-4424 Director 1 X M 2 - F 61 June 24, 1951 th and Mental Hygiene. 27 is merked other then "natural", or items 23a or 28e-f show treumetic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location with the Meryland 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 5917 Barbados Place 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. Š 1 Never Married 2 Married 1 X Yes 2 X No land 21215-0036 If Yes, Give Year or Dates 1972–1981 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) National Institues Elementary/Secondary (0-12) College (1-4 or 5+) of Health should be filed with h and Mental Hygien 7 is merked other th Electrical Engineer 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grant Jensen Emma (unk.) l end 2 should b f Health and Mer tem 27 is merk Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannit. Page 1 enc.
Depertment of Healt.
Importent: If Item 27
any Injury or off-320 Laurel Avenue, Fredericksburg, Virginia 22408 Mike Jensen/Son Released Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Johnson Crematory Locust Grove, Virginia 4 Donation 5 Other (Specify) 3, 2012 21. Signature of Funeral Service Licepa 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Bethesda-Chevy Chase, Inc. Maryland 20814 Mulha M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one value on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Subdural Physician Complications disease or condition Medical resulting in death) Due to (or a a consequence of): mE Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physicien: The iew requires that the detah certificate be within 24 hours after death.
To the Funcrei Director: After this certificate hes been signed by the attending physicis compilelay filled in by the funeral director, page 2 should be detached for use as the burneral compileraly filled in by the funeral director, page 2 should be detached for use as the burneral compileraly filled in by the funeral director, page 2 should be detached for use as the burneral compileraly filled in by the funeral director, page 2 should be detached for use as the burneral compileration. 3457AM Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown 9/13 PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an performed Yes 2. N Be Jense **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1
Yes 2 □ No မူ 1. ■ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred policed down 28c. Injury at injury 1 Natural 5 Pending (0:05 PM 10/25/12 1 Yes 2 No 2 Accident hill Investigation by dog he was walking eonard 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (S reet an Number or Rural Route Number, City or Town, State) determined intersection Grounds of Grorenan Tower Apt Tucherman Lane With Rockni 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 10 enu D13943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Drive, Ste. 4920, Bethesda, Maryland 20817 Shih-Chun Lin, M.D. 31. Date filed (Month, Day, Year State NOV 0 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh c933 11-2-12 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Regis C. Hershm 650 M OCHOLER31 2017 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CANGILSTON Boltimora HUSA-H-1 Centa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 04/16/1933 Country) Min. 218-28-2182 1 - M 2 - F Md. Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "neturel", or items 23a or 28a-f shoother treumatic event, the Medical Examiner must be notified at. 10a, State 10h County Director Baltimore 1 Yes 2 X No Randallstown 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21208 USA 3712 Parkfield Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩idowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Microbiology Labratory Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Rena M. Toffrey Richard B. Traylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 401 Kalorama Rd. Sykesville, Md. 21784. Rose Pentz permit. Page 1 and 2 Department of Healt Important: If item 2 any Injury or other t Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation 11/02/2012 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physiciani Broscho Due to (or as a consequence of): Medical resulting in death) Examiner CONC OAS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 CA Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA |요 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 029085 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21135 T. 31. Date filed (Month, Day, Year) 32. Assistrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

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Please amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item 1 per doc 2933 T1-9-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Geraldine O. Krecher 2. Date of Death 3. Time of Death Physician/ 01:00 A 12 ALDIO Medical 4a. Facility Name (if not institution, give street and number) Gity, Town, or Location of Death 4c. County of Death **Examiner** THINE ARUNDE SADENA 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 8. Date of Birth Year **Funeral** 1 M 2 F Months Hours Min. (Month, Day, Country) Days MD. Yrs **Director** Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No ADEN D ARUNDE 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other than "natural", or items 23a or marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a may injury or other traumatic event, the Medical Examiner must be a Funeral ERNECK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces' Black White etc. 1 Never Married 2 Married ò Yes 2 ₩ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhITE 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ASHIER Z Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NECK RD. PASADENA KUBIN ANNE MD. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 s Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARUNDEL CREMATORY 10-30-12 ODENTON, MD 22. Name and Address of Facility DAUQHERTY FUNERAL HOME EGO! MOUNTAIN RD. PASADENA 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one call on each line Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final (on us Physician/ year disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami transit. the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): burial been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) g Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an cate has by page 2 s autopsy After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 Other: 4 Nursing Home Hospital: မ 1 Tes 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of De 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 395 0 MD our 2012

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

only one 29b. Signature ar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

01

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE HEACH OWSON DULANCY If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 053-46-**Director** 1 M 2 F ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral BONSAL ZZ 122 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify is marked other than "natural", 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SEAMSTRESS J 050 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stellios ThodorA 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 2/23/ 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place -2012 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses oseph 4021224 23a. Part 1. Enter the shock, or heart ee, or complications that caused the death. Do not enter the mode of dying, List only one cause which line. Approximate Interval Between ch line Immediate Cause (Final disease or condition Onset and Death Physicians 2 6 1 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn ☐ Yes 2 ☐ No ☐ Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred Natural 2 Accident injury work? 5 Pending 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Pytacifitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) 10.30.1.6 be of death (Item 23a) (Type, Print), Fint 30. Name and address Oster NOV 0 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last)
Shirley Jean 2. Date of Death Kurre Physician/ Month 10/17/12 4:40 am M Medical 4a. Facility Name (if not institution, give street and number)
St. Mary's Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. cial Security Number 493–36–5866 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 77 **Director** 1 🗆 M 2 🗶 F 10/29/34 MD Usual Residence of Decedent show 10c. City, Town or Location Lexington Park 10a. State 10b Count 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director St. Mary's 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 46860 Hilton Drive Apt 2911 20653 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. Completed 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Gonernment Contractor 12 Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Statler 17. Father's Name (First, Middle, Last) and Mental I 1 and 2 should be file of Health and Mental item 27 is marked o ဂ Clyde Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Kelly Knapp / Daughter 21625 America Street, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 😾 Removal from State Russell Heights Cem. 10/24/2012 Jackson. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 F. Fort Avenue, Baltimore MD 21230 re of Funeral Service Licensee Victor P. Doda 0,000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician o cardial disease or condition resulting in death) my Medical **Examiner** pretor Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physiciar Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypernatremia, dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? al Kelosis 24a. Was an Metabolic autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) or Attending Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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17/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per dvr g933 11-2-12 vt State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1350 BWE ICHARD 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESHOSAKE MUDICAL HA GNIDW A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** Min. 227-22-2793 1 X M 2 🗆 F Director 86 APRIL 20,1926 NORTH CAROLINA Usual Residence of Deceden 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 28a-f MD. HARFORD **EDGEWOOD** 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 59 LITTLE CREEK LANE 21040 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married ò 1 ¥ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ▼ No Specify WHITE "natural", Completed 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than "r AUTOMOTIVE Elementary/Secondary (0-12) College (1-4 or 5+) LINE TECHNICIAN **INDUSTRY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JARDAN LOVE RUTH HODGES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau LYDIA M. LOVE **SPOUSE** 59 LITTLE CREEK LANE EDGEWOOD, MD. 21040 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 10-29-2012 GLEN BURNIE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERALHOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician/ RUBABUS Medical Examiner UNKNOWN unapy Recumulally list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 09289 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the at be detached for 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Frantitioner: To the best of my knowledge death one down as regreen been delegants and of sub-bens lends been over lemit and he be 29b. Signature and title Pertifier D 65966 Swaps address of person who completed cause of death (Item 23a) (Type, Print) SOUVEROR CHOSARDAKE A

DHMH 17 Rev 06-2011

State

Registrar

VOULLA 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra Date of Death 1. Decedent's Name (First, Middle, Last) Year 2 Physician/ MARIE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Augsburg Lutheran Home Lochearn Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 219-07-1815 Director 1 M 2 V F Jan. 13,1916 New York 96 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location the Maryland items 23a or 28a-f sho ner must be notified at Director MD Baltimore Lochearn 1 Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21207 6811 Campfield Road Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status 12, Was Decedent Ever in U.S Examiner Armed Forces's Black, White, etc. ö ģ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 White 1 🗌 Yes 2 🗶 No Specify. If Yes. Give "natural", Completed 3 X Widowed 4 Divorced Year or DatesWWII the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Veterans Administration ed other than 'event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ant of Health and Mental Hit: If item 27 is marked otly or other traumatic even မ Ellen Fitzpatrick Joseph McGee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Ritter 2029 Arabian Drive; Finksburg, MD 21048 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth cemetery, crematory or other place. X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 11/2/2012 Baltimore, MD Other (Specify) 4 Donation 2. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licensee Mo123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HHEROSCLEROTIC Immediate Cause (Final EREBRO VASCUI Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 É as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month for Year Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEBILITY 1 Yes 2 No 3 Probably 4 Onknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy No 1 🗌 Yes certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer iniury work? Natural 5 Pending ☐ Accident Investigation Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

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Registrar
DHMH 17 Rev 06-2011

130. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM CAKHANI, MD. P.D Box 1525 OWINGS MILL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 14, per fh, g933 11-2-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 36 Physician/ Lauer Diane Medical 4a. Facility Name (if not institution, give street, and number) or Location of Death 4c. County of Death Examiner mor NA T Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Unk. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 480-50-5168 70 Director 1 □ M 2 🗓 F 09-15-42 Page 1 end 2 should be filed within 72 hours effer death with the Maryland ment of Heelth end Mentel Hyglene. ent: If Item 27 is marked other then "neturel", or items 23e or 28e-f ehow ury or other treumetic event, Ite Medical Examinar must be notified at 10b County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1XX Yes 2 ☐ No Baltimore Catonsville MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 USA 701 Edmondson Avenue 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African

Caucas I an

Specify: Anie 21 Can <u>چ</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk. State of Maryland ŇA 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. unk. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #611611 Central Avenue Towson, Maryland 21204 Suite Donna Brill- Guardian Baltimore, Place of Disposition (Name of cemetery, crematory or other place)
 Mt. Zion Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Importent: If eny Injury or 11-01-12 Lansdowne, MD. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Ligense 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ Artenoselevotic ease or condition Oronary Known Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sete hes been signed by the ettending physicien end pege 2 should be deteched for use as the burlei-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No this certificete 1 ☐ Yes 2 ☑ To the Hospital or Attending Physicien: "within 24 hours efter death.

To the Funerel Director: After this certifica completely filled in by the funerel director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 2/ Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Tergesin 31. Date filed (Month, Day/Year) 32. Registrar's Signature State NOV 0 2 201

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ LAFON 11:00 A M DCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GLEH BURHIE JEGUURA UHA BACTI HORE - WASHINGTON HEDICAL CENTE If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-42-3655 1 □ M 2 🏝 F **Director** Dec. 5, 1945 Maryland 66 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shormust be notified at Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 United States 521 Manor Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. "natural", or iterr ledical Examiner r 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the Hospital Administration Balt. Wash. Med. Cntr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental Ith 27 is marked or traumatic eve ပ Thomas L. Wist Bessie Hoover t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Manor Road, Glen Burnie, MD 21061 Paul H. Lafon, III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 11/02/2012 Baltimore, Maryland 4 Donation Other (Specify) Cedar Hill Cemetery ve of Floo rail S 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Sign 421 Crain Highway SE, Ğlen Burnie, Maryland 21061 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final disease or condition SEPTIC SHOCK DAY Medical resulting in death) Due to (or as a consequence of) **Examiner** 24405 Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 Month Day 1 Yes 2 No 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 K Unknown Completed PANCREATIC CANCER page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital ပ 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours af Funeral Di etely filled i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OM confined and morrolling 11553000 0CtoBER27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

CUILLERMO JOSE CIANCRECO

31. Date filed (Month, Day, Year)

NOV 0

301 HOSPITAL DRIVE, CLEW BURNIE, MD 20161

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State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0124 hrs October 30, 2012 **Medical Examiner** Steven Paul Matisans 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Bel Air 501 Greenridge Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 223-61-3349 Dec. 1, 1990 Country) Virginia Director 21 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County and a 1 Yes 2 XNo Bel Air Harford Maryland r items 23a or 28a-f show t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trunent of Health and Mental Hygiene.

Tranti: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 USA 501 Greenridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 X No Yes Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Baltimore, MD 21215-0036 Carpenter 12 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Mary Anne Coradine Steven Douglas Matisans Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 Greenridge Road, Bel Air, Maryland 21015 Mary Anne Sanford / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Bel Air, Maryland 11/3/2012 Bel Air Memorial Gdn. Dopation 5 👩 Other Specify: 21/Sign ture of Fundal Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication Physician Between Onset and failure. List only one cause on each Medical Death a Narcotic (Free Morphine) Intoxication Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ician/Medical AMENDED 23a, 27, 28a-f, per me, g934 12-12-12 sm X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown Š Completed 24b. Were autopsy findings available 24a. Was an this certificate has been: prior to completion of cause of autopsy performed?

✓ Yes 2 No death? 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification 1 Natural unknown 1 Yes 2 X No 5 Pending fd 1:09 am fd 10-30-12 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State) 501 Greenridge Rd. determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 31, 2012 O.C.M.E leted cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Theodore M. King, Jr., MD 32. Registrar Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 25°, Physician/ 2012 3:41 P Marth Marie Agnes Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 218-76-6357 Feb. 25, 1958 Colorado 1 □ M 2 😾 F 54 Usual Residence of Deceden or then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20715 United States 2515 Kitmore Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any loinry or other treumatic event 20te. 17. Father's Name (First, Middle, Last) Agnes Mroczkowski Ronald Robert Marth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 Galen E. Hornick / Son 2515 Kitmore Lane, Bowie, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
Chesapeake Crematory 10/29/2012 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Beltsville, MD 4 Donation 5 Other (Specify) Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD Signature of Fugeral Service Licensee 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner pirate Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Ence Hospitai or Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the burlal-transif that initiated events Due to (or as a consequence of) resulting in death) Last Monor Physician/Medical Cerrhon Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ Month Day Pregnant at time of death been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has perform 1 ☐ Yes 2 ☐ No this certificate 24 hours after death, Funeral Director: After this certifical etely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Da Inpatient 2 ER/Outpatient 3 DOA ည Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 V Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely To the I within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D-18895

State

IKARIM, 7610 CARROLL AVE, STE340, TAKOMAPALL, MD 2091

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

MOBARAY.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 5:30 P M October Montgomery Stewart Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery Med-Star Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Hours Months 204-18-4256 1 XM 2 □ F 88 **Director** July 16, 1924 Pennsylvania Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10a. State Completed by Funeral Director 1 Yes 2XXNo MD Montgomery Ashton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 17943 Pond Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2 □ No If Yes, Give Year or Dates. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Organic Chemist Private Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Montgomery Anna John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17943 Pond Rd., Ashton, MD 20861 Maxine Montgomery / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 11/01/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD MØ154 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypotensian disease or condition resulting in death) Medical a consequence of phos **Examiner** SCASIS Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure HTN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? Yes 2 No 1 Yes 2 No funeral director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Med Direch 29c. License number 29b. Signature and title of certifier while 00050410 10/29/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Which ac I Kerr MD 18101 Pornec Philip & Clary, MB 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and Ment	al Hygiene							
		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 2 3 5 U 9 3 ate of Death							
Physici		Richard Joseph Mulhare Sr.		onth Day Year 1 - 1 5							
Med Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
		744 Rustling Leaf Court 5. Social Security Number 6. Sex 17. Age (in vrs. last birthday)	Sykesville	Carrol1							
Funera Director	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 153-30-5529 1 X M 2 🗆 F 73 Yrs.	Months Days Hours Min. (M	ate of Birth 9. Birthplace (State or Foreign Country)							
d to w	٦.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	<u> </u>	r 7 1939 NJ							
larylan 8a-f sh ified a	Director	100.00,10000	esville	10d. Inside City Limits 1 ☐ Yes 2 X No							
the Manager	ä	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
th with ns 23 must I	Funeral	744 Rustling Leaf Court	21784	USA							
or iter	by Fu	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	es or No- etc.) 14. Race - American Indian, Black, White, etc.							
DO3(ural", ul Exar	ted t	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes Give Year or Dates.	1 Yes 2 No Specify:	Specify: white							
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212 within giene. er thau	ပ်	Elementary/Secondary (U-12) College (1-4 or 5+)	DO NOT use retired) Curity officer	U.S. Navy							
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Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	-	Paul Mulhare		. Tagliazucci							
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Baltim permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Page Naight Herbert P	2. Name and Address of Facility Haight .O. Box 195 Sykesville	Funeral Home & Chapel							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		ratory arrest, Approximate Interval Between							
Physician Medical		Immediate Cause (Final disease or condition resulting in death)	ev	Onset and Death							
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and due stigation, in my opinion, death occurred at the time	to the cause(s) and manner as stated. le, date and place, and due to the cause(s) and manner stated.							
o the inthin 2 the loomble!	Me	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the time, date and place, and	due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)							
P S P O		► Wrendlak OK	D62808	November 1. 2012							
9		30. Name and address of person who completed cause of death (Item 23a) (Type, WMAIA CHWA 305 HOSPITAL									
Sta		31. Date filed (Month, Day, Year) NOV 0 2 2012		1009 21001							
Registr	ar	MUY U & ZUIZ DENGEN JO. 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Doris DeWitt Milberger 10 30 2012 9:03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerford Place Assisted Living Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mache Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 12/13/1926 420-28-4853 85 Alabama Director Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinating that by Incilliated 1 Yes 2 No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2717 Riva Road 21401 USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify If Yes, Give "Year or Dates: 3

Widowed 4

□ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 4 Artist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be Pogue Unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 i Amelia M. Seman / Daughter 2022 Haverford Drive, Crownsville, MD 21032 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or ö ' 4 ☐ Donation 5 ☐ Other (Specify) 11/2/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chouska Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final emen **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certiticate be executed use as the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the al 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Dunknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? has 1 ☐ Yes 2 400 1 🗆 Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No Certification: To 1 Tyes 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00073574 and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 2012

1. Registrar's Signature factor

1. Registr State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown . Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 07/29/1946 Country) North Carolina Director 1 1 → M 2 □ F 228-66-1080 66 Usual Residence of Deced er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12110 Amblewood Drive 20708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Navy
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Credit Manager Manufacture permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည <u>Philip Meigs</u> Martha McDaniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Meigs / Wife 12110 Amblewood Drive, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/2/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has 1 🗌 Yes 2 🗌 No 1 Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to Medical 26. Place of Death (Check only one) Hospital: Other: 1 Tyes 12 D No |은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I only one and the of certifier 29b. Signatury 29c. License number who completed cause of death (Item 23a) (T 0 31. Date filed (Mo Year 2 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Felicie Catherine McGurrin 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/06/1919 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours New York Director 1 □ M 2 🗗 F 129-03-6805 93 Usual Residence of Dece ortant: If item 27 is marked other than "netural", or items 23a or 28e-f shov Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 □ No MD Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 2825 Lodge Farm Road, Apt. 408 21219 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No 1 ☐ Yes 2 💢 No If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Sales and Mental Hygie is marked other Be filed Maryland permit. Pege 1 and 2 should be filed Depertment of Health and Mental Hy Important: if item 27 is marked oft eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Black, Sr Lucy Godout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Sommerfield / Son 831 Beetz Road, Mount Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ieral Director: After this certificate has been signe filled in by the funeral director, page 2 should be 1 🗌 Yes 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 Ccident 3 Suicide 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date şigned (Month, Day, Year) State NOV 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #18, per fh, g933 11-15-12 sm
State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar	State of Ma	ar y lai it		tificate			ICI IVI		Reg. No.	onto	25007
	Physicia	n/	1. Decedent's Name (First, Middle,	,							2. Date of Dea		Year	3. Time of Death
-	Medic	al	Josephine 4a. Facility Name (if not institution.	Nwulia	7		45 O'A To				October	24 ^{Day}	2012 Year	1:30 A M
	Examin	er	Lorien Nursing & F			4b. City, Tov	olum		Jeatn		4c. U	ounty of Death Howard		
A.	Funeral				(In yrs. la	st birthday)	If Under 1		If Under 24	Hrs. Min.	8. Date of Birl		9. Birth	place (State or Foreign
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	nd show	or	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation						 _	10d. Inside City Limits
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036	s afte ral", c		3 ☑ Widowed 4 ☐ Divorced	NO	1	Yes 2	X No	Specify:			Sp	ecify: Blac	ck	
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Maryland 21215-0036	should and N is ma		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ig Address (St	treet an	nd Number o	r Rural			wn, State, Zip	Code)
Σ.	ealth m 27		Moses Nwulia	(Son)			Reedy Br		Lane		mbia, Ma	aryland	21044	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	CE	emetery, cren	sition (Name on natory or othe	of er place))	Da	ite UNK		tion - City or To	
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Ba	permit Depar Impor any in		21. Signature of Funeral Service Li	The second		55	. Name and A 555 Twin	aaress Kno	or Facility W	Vitzk ad	e Funera Columbia	al Home a, Mary	s, Inc. land 210	45
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Division of Vital Records,	l or Attending after death. Director: After d in by the fune	Certificate:	4 Homicide determin				et, factory, of	ffice		2	3f. Location (S City or Tow		umber or Rura	l Route Number,
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	Stat	e	31. Date filed (Worth, Day, Year)	32. Registra	Signat	re .	× 152	47	DW.,	351	196.16)	1.(1)	21	
	Registra	r	NUV U 2 2012	Cleveras B	. 4	acco								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 2012 William Leonard Nickel, Jr. 11:40 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days (Month, Day, Year 15, Hours Min Mary land 1922 Director 214-16-8905 1 X M 2 🗆 F 90 Mar Yrs r then "natural", or items 23a or 28e-f sho the Medical Examiner must be notified at 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Freeland 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21053 USA 20517 Keeney Mill Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health end Mental Hyglene.
Important: If item 27 is marked other then "ne
eny injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Merchant Marines (unk) Crew Member Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gussie Levenduski William Leonard Nickel, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Ellens Choice Way Parkton, MD 21120 Rhonda Snyder/granddaughter/POA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Final Journey Crematory 11/02/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Going Home CRemation Service MO1251Beverly L. Heckrotte, P.A. C P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or conditi-resulting in death) BLADDER CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospitei or Attending Physician: The law requires that the death certificate be executed for use as the burial-trens Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Records, P.O. Box 68760 NICKEL IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 K Other (Specify) HOSPICE ၉ 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funel completely fi 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

TRACIE L.

31. Date filed (Month, Day, Year) NOV 6 2 2012

a.m.

11:40

2012

OCTOBER 30,

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) CRNP

32. Registrar's Signature

MORGAN,

29d. Date sigged (Month, Day, Year)

TIMONIUM, MD 21093

2012

12-07735 Whitney Ancil Nesb	Please Type or Print in Black Indeli				
Williney Allon West		ent of Health and Mental Hygiene ate of Death	2012 35091		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of Deat	th 3. Time of Death		
	4a. Facility Name (if not institution, give street and number) Northwest Hospital	4b. City, Town, or Location of Death Pikesville	4c. County of Death Baltimore County		
Funeral Director	5. Social Security Number 105-66-0317 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24Hrs. 8. Date of Birth Months Days Hours Min. 11/2	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY		
Maryland 28s-f show any d at once. rector	Usual Residence of Decedent 10a. State	Windsor Mill	10d. Inside City Limits 1 Yes 2 XNo		
the Maryland a or 28a-f sho tiffied at once. Director	7 B Alset Court	10f. Zip Code 21 244	10g. Citizen of What Country? USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:	White, etc. African American Specify:		
5-0036 ed within 72 hours afti stygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12	Decedent's Usual Occupation (Give kind of work done furing most of working life. DO NOT use retired) Driver	16b. Kind of Business/Industry Delivery Service		
1215-0 1 be filed wental Hygical other vent, the New Year,	Lesite Ancii Nesbit	18.Mother's Name (First, Middle, M Mayleen	Patterson		
MD 21 nd 2 should alth and Me m 27 is ma "aumatic cv		Mailing Address (Street and Number or Rural Route Num 7 B Alset Court, Windsor M f Disposition (Name of cemetery, Date			
imore, Pages 1 an ment of He tant: If ite or other tr	1 Burial 2 Cremation 3 K Removal from State ROSEC	dale Mem. Park 10/19/12	20c. Location - City or Town, State Linden NJ		
	21. Signature of Funeral Service Licensee Victor P. Doda 23a. Part I. Enter the disease, or complications that caused the death. Do not	22 Name and Address of Facility Charles L. Stevens Funera 1 1501 E. Fort Avenue, Balt	imore MD 21230		
Physician /Medical ====================================	failure. List only one cause on each line. Immediate Cause (Final disease a Cardiac Arrhythmi	,	Between Onset and Death		
5	Sequentially list conditions. b. Dilated Cardiomeg.	aly			
ted d ansit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
0, be executed sician and ourial - transit	X UNPENDED AMENDED 23a-b, 27, pe	r me,g933 11-8-12 sm			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician pletely filled in by the funeral director, page 2 should be detached for use as the burildical Certification: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year		
s, P.O. lires that the signed by to detache			bacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
tal Records, lian: The law requires certificate has been sig ector, page 2 should be Be Completed		24a. Was a autopp perfor 1 ✓ Yes 2	sy prior to completion of cause of med? death?		
F Vital Rec Physician: The r this certificate I ral director, page To Be Corr	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	26.Place of Death (Check only one) tpatient 3 DOA Other Nursing Home 5 I	Residence 6 Other:		
ion of tending Pl eath. tor: After the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work? 28d. Describe h	now injury occurred		
Division o spital or Attending nous after death. If the filled in by the function: After the function of the f	3 Suicide 6 Could not be determined (Specify)	rm, street, factory, office building, etc. 28f. Location (S or Town, St	street and Number or Rural Route Number, City tate)		
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification: T	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the cause vestigation, in my opinion, death occurred at the time, date a	and place, and due to the cause(s)		
•	29b. Signature and title of certifier (ar de Halla	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 13, 2012		
		0 W. Baltimore Street, Baltimore, MD 21223			
State Registrar	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Marie Onda 26, 5:34 p M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5713 85th Avenue New Carrollton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Apr 28, Davs Hours Min. Director 210-20-7175 84 1 M 2 XF 1928 Pennsylvania Yrs. 10a, State 10b. County ms 23e or 28e-f sho 10c. City, Town or Location 10d. Inside City Limits Director Prince George's New Carrollton 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 5713 85th Avenue 20784 USA er than "naturel", or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h end Mental H 7 is marked of မ Harry Swory, Sr. Nellie Bembenek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5713 85th Avenue New Carrollton, MD 20784 permit, Page 1 and 2 sh Department of Health er Importent: If item 27 is eny injury or other treu once. John Robert Onda/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/01/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the Vsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) months Physician/ Respiratory Failure Medical Due to (or as a consequence of) Examiner Chronic Obstructive Lung Disease 2 years Sequentially list conditions, if any Irradictly to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or as a consequence of) Exami ettending physicien and I for use as the burial-transit that the deeth certificate be executed 2 years Lung Mass Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 XNo **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 ☐ Yes 2 → No Other: To the Hospital or Attending Physi within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 9c. License number D16273

10 W

State Registrar Revathy Murthy, M.D. 6130 Landover Rd. Cheverly, MD 20785

31. Date filed (Month, Day, Year)

NOV 0 2 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #295 regression Mary 6934 declarated Please Type or Mary 6934 declarated Please Type or Mary 6934 declarated Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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502			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										av Year	3. Time o		
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(X	Examin	er	4a. Facility Name (if n	, 0		er)	4b. City, Town, or Location of Death					40	4c. County of Death Baltimore			
N	Funeral		662 1 5. Social Security Nur	Kenningtonber 6. Se		. Age (In yrs. la	st birthday)	If Under 1	Year	terst If Under 2	24 Hrs.	8. Date of Birt		9. Bir	thplace (State	or Foreign
=	Director		174-40-18	56	⊠ M 2 □ F	63	Yrs.	Months	Days	Hours	Min.	(Month, Day				
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2	with th	Funeral Director	662 K	enningto	n Road				211	36				U.S	.A.	
1/52/01 Adom	Jeath items ier m	Fun	11. Marital Status		12. Was Deced	ent Ever in U.S	6. 13. V	Vas Decede f Yes, specif	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
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$\frac{1}{2}$	ould but the mark		19a. Informant's Nan				19b. Mailir	na Address ((Street ar	nd Numbe				or Town, State, Z	p Code)	
	d 2 sh alth ar 27 is		Dorothy			Wife						Reister			21136	
ā	of Herritem		20a. Method of Dispo				Place of Dispo	sition (Name	e of her place	e) .	12/1	9/2012	20c. l	Location - City or	Town, State	
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Baltimore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hea		21. Signature of Fund	eran Service Licens	. / 1	Mi		. Name and				324 Rei Reister		rstown H	Road 21136	
		Н	23a. Part 1. Enter th	e disease, or com	plications that ca	used the death								WII FID	Approxima	ate
13	Physician/		Immediate Cause (F	failure. List only o inal	ne cause on eac	1	10								Interval Be Onset and	tween Death
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Box 6	ath ce attend for us	cian	23b. Was decedent p in the past 12 m 1 Yes 2	onths?	1 Live E	irth 2 Feta	aldeath 3 L	Ectopic p		у				23d. Date of de Month	Day	Year
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Vita	ysicia ysicia s cert direct	To Be	examiner? 1 Yes 2		Hospital:	npatient 2 🗆	ER/Outpatie	nt 3 🗆 DO	Othe				dence	6 ☐ Other (Spe	cify)	
4	Attending Physician: The extent and additional Addath. Extent: After this certificate by the funeral director, paging		27. Manner of Death	5 Pending	28a. Date o	of injury n, Day, Year)	28b. Time o injury	f 28	Bc. Injury work	?		28d. Describe l	now inju	ury occurred		
.5	ttendi death tor: A / the fi	tifica	2 Accident 3 Suicide	Investigatio		of Injury - At ho	me form str	M not factory		Yes 2	No	28f Location (Stroot	and Number or R	ural Route Nun	nher
Division of Vital Becords	l or A after Direc	Cer	4 Homicide	determined		g, etc. (Specify		eet, lactory,	Onice			City or Tov			artir roate rum	,,,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certificate:	29a. Certifier 1	Certifying Phy Medical Exam	sician: To the be	est of my know	ledge, death	occurred at	the time	, date and	l place, a	nd due to the c	ause(s)	and manner as	stated.	nanner stated
	the H hin 24 the Fu	Me	only one) 3	Certifying Nui	se Practitioner:	To the best of r	my knowledge	, death occu	irred at th	ne time, da	ite and pla	ace, and due to	the cau	ise(s) and manner	as stated.	
_	5 With 5 Co		29b Signature and t	itie of certifier	w n	2.00		29c.	License	number	7		29d. E	Date signed (Mon	0	2
			30. Name and addre	ss of person who	completed cause	e of death (Item	n 23a) (Type ii	Print)		Q Q			-	10 201 2	1,201	
bt	1		70. Name and addre	Milit	ello, M	DGTY	imbl	e 11:1	ICT	Luff.	heru	ille, M	D	2100	53	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10 Month Physician/ 2012 10:45 P M Glenwood W. Overacre Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air 2405 Cool Spring Rd. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 229-32-0673 Director 1 X M 2 D F 83 VA 08/22/1929 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21015 2405 Cool Spring Rd. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Year or Dates. Army If Yes. Give White 3 X Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic. Western Electric Electrician Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hatty Breeden 2 Elmo Overacre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 216, Forest Hill, MD 21050 Allan Overacre - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State Bel Air Mem'l Garden 10/27/2012 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Other (specify) signed by the at Id be detached fo Inknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 🗌 No should peen 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sempletely filled in by the funeral director, page 2 sempletely filled in by the funeral director. autopsy performe 1 ☐ Yes 2 ☑ No Yes 2 W To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\subseteq \text{Yes} Hospital 2 - No 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar only one)

31. Date filed Md

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Typen)

wx1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward O'Quinn	S 1- For State Registrar	tate of Maryla		artment of <i>tificate of</i>		d Mental		2 (Reg. No.	12 3510
Physician/ Medical Examiner	1. Decedent's Name (First, Midd EDWARD O'QUI	. ,					2. Date of De		3. Time of Death 0725 hrs
	4a. Facility Name (if not instituti	on, give street and num	nber)	4	b. City, Town, or Baltimore	Location of Do		4c. County o	f Death
Funeral	Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Yea			Birth (MM/DD/YYYY)	9. Birthplace (State or
Director	215-19-5812	1XM 2 F	29	Yrs.	Months Day	s Hours	Min. 1-22-	1983	Foreign MARYLAND Country)
, any	Usual Residence of Decedent 10a, State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show any d at once rector	MD . 10e. Street and Number	N/A		В	ALTIMORI	E		40.00	1 Y Yes 2 No
the Maryland n or 28a-f sh iffed at once Director	5411 OMAHA AV	FNIIF			10f. Zip Code	ς.		10g. Citizen of What	at Country?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X N	12. Was Dece	dent Ever in U. ces? 2 X No	If Ye		panic Origin? , Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	Io- 14. Race - White	
ours aft atural" camine	15. Decedent's Education (Spe	or Dates:	completed)	16a. Decedent	's Usual Occupat	ion (Give kind		Specify: 16b. Kind of Bus	WHITE iness/Industry
5-0036 ed vittin 72 hour. tygiene. the Medical Exan	Elementary/Secondary (0-12)	College (1-	4 or 5+)		ost of working life. E INSTAI		retired)	TELECOM	MUNICATIONS
MD 21215-0036 do 2 should be filed within 7 alth and Mental Hygiene. m 27 is marked other than a unnatic event, the Medica To Be Comple	17. Father's Name (First, Middle	, Last)		CABL			ame (First, Middle,	Maiden Surname)	MUNICATIONS
ore, MD 21215-(s) and 2 should be filed to of Health and Mental Hygi If Item 27 is marked oth her traumatic event, the TO BE CC	EDDIE G. O'QU 19a. Informant's Name/Relations			19b. Mailing	Address (Stree		A. KASM	IASEK umber, City or Town	State Zip Code)
MD d 2 shoulth and 1 in 27 is numatic	KATHE O'QUINN		MOTHER	5411	VA AHAMO	/ENUE	BALTIMO	RE, MD.	21206
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal from	n State	rematory or oth			Date UNK		City or Town, State
Baltimore, Department of Hea Department of Hea Department of Itee	4 Donation 5 Other S 21-Signature of Funeral Service		AT		CREMATOR	RY			JRNIE, MD. ERAL HOME, INC
	Wani	rle		64	15 BELA	ER ROAD	BALTI	MORE, MD	21206
Physician /Medical Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	nd Coc	aine In			ac or respiratory ar	rrest, shock, or hear	Approximate Interval Between Onset and Death
	Sequentially list conditions,	b							
ted Instit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С							
nuted ransit	events resulting in death) Last	Due to (or as a c	onsequence of):					
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ox 687 eath certific eath certific properties as the for use as the second or the seco	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 Live bin	nt at time of dea	2 Feta	al death 3 [er (Specify)	Ectopic pre	gnancy	23d. Date of d Month	lelivery Day Year
O. E hat the ced by the tetached	Part II. Other significant condi-	tions contributing to c	death but not re	sulting in the ur	nderlying cause g	iven in Part I.			ute to the cause of death?
ords, P.O. B wrequires that the d is been signed by the should be detached pleted by Physical							1Ye		Probably 4 Unknown ere autopsy findings available
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by Partification: To Be Completed by P	25. Was case referred to medica				26 Please	of Death (Che	auto perfo 1 ✔ Yes	psy pri orm <u>ed</u> ? de	for to completion of cause of eath? Yes 2 No
f Vital Physician: ar this certi ral director To Be	examiner?	Hospital:	patient 2	ER/Outpatient		Othor	rsing Home 5	Residence 6	Other: Scene
n of ding Pt	27. Manner of Death 1 Natural 5 Pen	28a. Date of (Month, D	Injury Day,Year)	28b. Time of In		y at Work? es 2 X No	28d. Describe	how injury occurred	d
Division of 'Division of 'To the Hospital or Attending Physiphin 24 hours after death. To the Funeral Director: After tecephetal filled in by the funeral endical Certification: Tederal	2 Accident Inve	stigation 10 10	of Injury - At ho		U am , factory, office b		28f. Location	(Street and Number State) 5411 Or	or Rural Route Number, City
To the Hospi within 24 ho. To the Fune completely fi	29a. Certifier 1 Certifying P	hysician: To the best of miner:On the basis of and manner sta	examination ar				and due to the cau	se(s) and manner a	
	29b. Signature and title of certific		acr		29c. License O.C.M			29d. Date signed October 29,	(Month, Day, Year) 2012
θ	 Name and address of persor Carol H. Allan, MD 	who completed cause Assistant Medica			altimore Stre	et, Baltimo	re, MD 21223		
State Registrar	31. NO Ved Mazin 2012 ar)	Jenna 32. Regi	stra 's Signadu	ales					

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loel Anderson Od		1- For State	State of Maryla	•		it of Health a e <i>of Death</i>	and Mer			201	2 35 10
Physicia		Registrar 1. Decedent's Name (First, Mi	ddle,Last)		- Innout	o or boath		2. Date of De	Reg. No. eath		3. Time of Death
Medical Examin		JOEL ANDERSON	N ODOM					Month October	Day 22, 2012	Year	2316 hrs
		4a. Facility Name (if not institu 262 Belle Hill Road		mber)		4b. City, Town Elkton	, or Location	of Death	4c. Co Cec	unty of Death	
Funeral Director		5. Social Security Number 255-43-4475	6. Sex	7. Age (In yrs 45	s. last birthd		Year If Und Days Hours		1967	Faraina	nplace (State or n ntry) GEORGIA
è	-	Usual Residence of Decedent 10a. State 10b. Coun		110c. C	ity, Town or	Location		<u>-</u>			10d. Inside City Limits
p de s			AYTON		OREST						1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1122 HOLLY CR		<u> </u>		10f. Zip Cod 3029			10g. Citizen USA	of What Coun	try?
with th		11. Marital Status		edent Ever in	U.S. 1			gin? (Specify Yes or N			can Indian, Black,
death or iten	Funeral	1 Never Married 2	Married Armed F	orces? 2 χ No		If Yes, specify Cu	ban, M exicar	n, Puerto Rican, etc.)		White, etc.	
after			Divorced If Yes, Give Yes or Dates:	r		1 Yes 2 X					ITE
hours frature	g g	15. Decedent's Education (S Elementary/Secondary (0-1				cedent's Usual Occu ing most of working			16b. Kind	of Business/Ir	ndustry
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5-00 ed wit flygien of ber	Completed by	17. Father's Name (First, Mide	dle, Last)				18.Mothe	r's Name (First, Middle	, Maiden Suri	name)	
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AD 2. 2 should h and M 27 is m	유	19a. Informant's Name/Relation BRENDA ODOM-MO				Mailing Address (S 22 HOLLY (mber or Rural Route No REST PARK,			Zip Code)
re, Fred I and Fred I f	1	20a. Method of Disposition 1 Burial 2 X Cremat	tion 2 Demoval fr			Disposition (Name of or other place)	cemetery,	Date	20c. Loca	ation - City or 1	Fown, State
Pages nent of		4 Donation 5 Other		M		CREMATORY		10/28/12			CITY, GA
Salti ermit. epartn mport njury	1	21. Signature of Funeral Serv	ice Licensee	-				y MILLER-D			L HOME
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Examiner	- 1	or condition resulting in death			e of):						
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executed an and al-transit	Exa	events resulting in death) Las	st Due to (or as a	consequence	e of):						
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876(ifficate ig phys	Ž	IF FEMALE: 23b. Was decedent pregnant in		outcome of pr	egnancy 2	Fetal death	3 Ectopi	c pregnancy	23d. Da Moi	ate of delivery	ay Year
ox 6	Physician/Med	past 12 months?	4 Pregr	ant at time of		Other (Specify)					,
the de	돌	Part II. Other significant con	9 01101		t resulting in	the underlying cau	se given in P	art I. 23e. Did	tobacco use	contribute to t	he cause of death?
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v requi	Set							24a. Wa auto	s an 2 opsy		opsy findings available ompletion of cause of
RecC The lav	Completed								formed?	death? 1 ✔ Yes	2 No
tal F	BB	25. Was case referred to med examiner?	Hospital:					(Check only one)			
F Vil Physic er this	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	npatient 2	<u> </u>	atient 3 DOA	Other ₄	Nursing Home 5 28d. Describe		6 Other:	Scene
ion o ttending death. :tor: Aft	ation:	1 Natural 5 P	ending Oct 22,	Day Year) 2012	0000 h		Yes 2 ✓	- Subject as		Souli Gu	
Divis	Certification:	4 V Homicide	ould not be	e of Injury - At Hotel	t home, farm	, street, factory, offic	ce building, e			iumber or Rur om 48, Elktoi	al Route Number, City n, MD
	Medical	(Onoth thin)	Physician: To the best Examiner: On the basis and manners	of examination	_						
4.34.8	₩ E	29b. Signature and title of cer		atou.		29c. Lic	ense number		29d, Date	signed (Mon	th, Day, Year)
		Thoolin M	1 Kina	TR	m,). O.	C.M.E.	OCME	Octobe	er 23, 2012	
		30. Name and address of personal Theodore M. King.				er 900 W Ra	Itimore St	reet. Baltimore M	ID 21223		
Sta	ate	31. Date filed (Manife Pay) (e.	26	egistrar's Sign	ature	7 A					
Registr		NUVU	2 ZUIZ Den	wa	1. 14	arke					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month The lma Pallante Gibson November :50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 277-14-6567 Director 1 M 2 X F March 20, 1919 93 Tennessee show should e filed within 72 hours after death with the Maryland and Mental Hygiene. ar than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Southerly Court, Unit 505 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Artist/Homemaker vears Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hubert Gibson Eller **Owens** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any Injury or other troones. Sharon Morell (daughter) 3 Southerly Court, Unit 401 Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. Timonium, Maryland 11-5-12 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 6500 York Road 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ HEART DISEASE Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Nuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🌠 No 9 ☐ Unknown yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 **X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State NOV 0 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robin Yvette Kane Prater 11:58 AM october 201 Medical 4a. Facility Name (if not institution, give street and number) Sinai Hospital of Ba **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Year)
March 18, 1957 Country) 215-66-2440 Director 1 🗆 M 2 🗓 F 55 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director MD 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4026 Hillen Road 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Š 1 Never Married 2 X Married 1 Yes 2 XNo 1 ☐ Yes 2 No Specify: SpecifyAfrican-American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Director of Guidence Poly Tech. Inst. | Baltimore CityPublic School Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental h Important: If item 27 is marked of any linjury or other traumatic ever once. ဂ္ Louis Kane Venciedora Howard Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron D. Prater, Sr. / Husband 4026 Hillen Road Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial ,2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 11/5/2012 Baltimore, Maryland 21. Signature of Juneral Service Lice See 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. لار Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Palient disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68766 A Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cholongiocancinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown and bones metastasu 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No Yes 2 V Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 124 hours after death. • Funeral Director: After this of the funeral direction by the funeral direction of the funeral direction. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hours to the second to the formula to the formula to the second to the secon 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Hartha 065718 October, 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE PENDLI MDI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 ar October Fave Heil Peterson 9:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 6962 Pindell School Road Fulton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 D M 2 X F Months August 13,1942 Director 220-40-3808 70 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 X No Marvland Howard Fulton 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 20759 U.S.A. 6962 Pindell School Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2x Married Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: If Yes Give 3 Divorced Specify. Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than Public Affairs Officier F.D.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Gaither Herbert Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. F.c. Department o, Important: If item v injury or other tre Michael Peterson 6962 Pindell School Road Fulton, Maryland 20759 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Columbia Memorial Park 11-3-2012 Clarksville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. M01050 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 No 3 Probably 4 Unknown 1 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Acciden 3 Suicide 5 Pending injury 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title

State Registrar

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who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto und

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31, 2012 6:35 p M Larry Wayne Page Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 5609 Emory Road Upperco Birthplace (State or Foreign Country) If Under 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours 213-42-4162 Director 1 X M 2 D F 69 23 1943 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 X No MD Baltimore Upperco 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5609 Emory Road 21155 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black White, etc. Yes 2 X No 1 Never Married 2 K Married þ altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Sales Automobiles Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewone. ပ James Norris Page Inez Pauline Peltzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicholas Page -8600 16th St. Apt. 615, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Carroll Cremation Nov. 2,2012 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Furtheral Service Licenses ELINE FUNERAL HOME Reisterstown, Maryland 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Athenoscle disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the k IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Day ☐ Pregnant at time of death☐ Unknown 2 No the a g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CANCER page 2 should mell. tos 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury 1 Tes 2 🗌 No s after death. 2 Accident
3 Suicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Heather Latinise Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LOUISA Palasik 3:26 P 30 2012 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Social Security Number 6. Sex last birthday) If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 18440776 1 M 2 Z Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MARYLAND Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō 7002 or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 2 10 Maryland 21215-0036 δ 3 ₩idowed 4 Divorced Specify: White "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) City FINANCIAL Kee Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be William ည Rural Route Number, City or Town, State, Zip Code) 215 CQ 19a. informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License YChOJNACKI TUNERAL much anh 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD **Physician** Year disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran and Due to (or as a consequence of) attending physician Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? l signed l 2 Records, pe 2 No 3 Probably 4 Nnknown After this certificate has been sig funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home မ 1 Yes 2 □ No 2 KER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation or Attending Injury 2 No 1 Yes filled in by the 3 🗌 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo October 30 2012 067667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -MO 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month egistrar's Signature State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:20 P OCTOBER 29,2012 STEVEN CHARLES PHOEBUS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UNIT D 1405 JOPPA FOREST DR. JOPPA. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
MAY 3,1951 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 213-58-4317 1 ☑ M 2 □ F 61 MARYLAND Usual Residence of Deceder 77 is merked other then "neturel", or items 23e or 28e-f show treumetic event, it e Medical Examer must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No **JOPPA** MD. HARFORD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 1405 JOPPA FOREST DRIVE 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. δ 1 Never Married 2 🕅 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 | h end Mentel Hyglene. 7 Is merked other then "n Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRONICS NATIONAL SALES DIR. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည MARGARITE HARTGE WILLIAM S. PHOEBUS permit. Pege 1 end 2 should be Depertment of Heeith end Men Importent: If Item 27 is merks eny injury or other treumetlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 JOPPA FOREST DRIVE UNIT D JOPPA, MD. 21085 **SPOUSE** KATHY PHOEBUS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD. ATLANTIC CREMATORY 11-1-2012 22. Name and Address of Facility ConTMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Cicenses NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4Lute Tyelord Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Finter Underlying Cause (Disease or injury Due to (or as a consequence of): inding physician end use es the buriel-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗷 No Month Dav signed by the e 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate hes been siç ; pege 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? After this certificate 1 ☐ Yes 2 🖫 No Yes 2 N To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 24-No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No М 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ture and title of certif 29b. Sigh 29d. Date signed (Month. Day. Year) 29c. License numbe MO 00047398 Ochober 31 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland B nouglas Snih 1650 orleans Bultimore Street

Registrar

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #8 Per FH G933 11/07/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, James **Physician** otober30 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) Hours Min. 8. Date of Birth (Month Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** 1 M 2 F Months 212-42-508 1944 MARY/AND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ms 23a or 28a-f show must be notified at 1 Tes 2 No Director TARYLAND 10g. Citizen of What Country 10f. Zip-Code 10e. Street and Number Bessemer Funeral death Race - American Indian, Black, White, etc. items Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iten permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite may hijury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WhrTo þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) WeyerhAeuser RRVISOR NA 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNA IOMCZ ewsh ၉ JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 1005 Dundalk Ave. ark noch Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): **Physician** /Medical resulting in death) Examiner Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner non small cell the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 1 Tes 2 | No 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No မ within 24 hours after death. To the Funeral Director: After this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: Natural 2 Accident Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ٥ 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, State parks? NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Allo Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown **Baltimore** Seasons Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Hours 216-78-1447 Director 1.M 2 . F Yrs 11/2/70 Maryland Usual Residence of Decedent 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10a. State death with the Maryland Director 1 🗌 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244-3129 USA 8339 Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Master Carpenter Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mentall Important: If item 27 is marked c any injury or other traumatic eve MaryLinda Folckemer John Michael Pillsburv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21218-2026 3608 Kimble Rd. Lois Scarborough 20a. Method of Disposition 20b. Place of Disposition (Name of Bartmettem or metro or etmantice) y 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park 11/1/12 . Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of rijury that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 □ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 100 ah on h 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) theyman 4 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1525 Box owings MD 21117 31. Mate filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Quinto rez1a 40 County of Death 4a. Facility Name (if not institution, give street and number) 4b Sity, Town, or Location of De Examiner everna If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Min (Month, Yrs. Director Usual Residence of Decedent show "natural", or items 23a or 28a-f shor idical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced SHITE Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 11-8-12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses daugherty funeral Home Name and Address of Facility Part 1. Enter the deepse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown jo Pregnant at time of death the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Yes 2 No 1 Yes ours after death. •eral Director: After this certifics filled in by the funeral director, I or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one 29b. Signatur 29d. Date signed (Month, Day, Year) DS31/1 2012 MD 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061 GLEN BURNIE MD

State Registrar

DHMH 17 Rev 7/2009

SUITE

BLUD

32. Registrar's Signature

AVIATION

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OCTOBER 31 WILLIAM LEE RICHARDSON 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LOCH RAVEN n/a BALTIMONE 5. Social Security Numbe 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day 1 XM 2 - F Min. 63 Virginia Director 214-46-1379 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be items 23a Funeral 734 Lake Path 21032 USA must death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter þ 1 X Never Married 2 Married ¥ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Office Furniture Installer Delta Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loyd Richardson Yetta Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 775 Shelton Road Apt3 Crownsville, Maryland 21032 Michael Richardson/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/1/2012 Baltimore, Maryland Significant of Funeral Service Licenses Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore. Maryland. 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician CARCINOMA HEAD AND disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending abusing and Due to (or as a consequence of): resulting in death) Last burialthe attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Af 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ()30272 00TOBER 31 2017

State

Registrar

3900 LOCH RANGO BOULDVARD BALTIMORE, MO ZIZIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILLER

32. Registrar's Sign

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vear Month **Physician** 3:35AM Sharon Diane Raber OCTOBER 2012 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DELC DELCAN
If Under 1 Year | If Under 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2**X** F 215 42 2394 68 Aug.12,1944 Kansas Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinat mast be redified at 1 □Yes 2 No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 705 S. Fountain Green Rd. USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or incorrect. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 □Yes 2 X If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Gordon Elizabeth Malpas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Raber Jr. (Brother-in-Law) 416 Campus Hills Drive Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 11/1/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home_P.A 21. Signature of Funeral Service Licensee dim 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Supranucle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Vear Day 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached formpletely filled in by the funeral director, page 2 should be detached for the funeral director. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an denver in autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mp Mich 32. Registra

State Registrar

SHARON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ANTHONX 10-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DACHINGTON MEDICAL Age (In yrs. last birth 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 85 Yrs. 1 ☑ M 2 ☐ F Director 10-30-UNSYLVANIA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🐼 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2106 5. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhITE 3 ₩Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TRUCKING Be Father's Name (First, Middle, Last) Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, 1 and 2 s of Health a item 27 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Department of h Important: If its any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1:10-31-12 4 Donation 5 Other (Specify) ODENTON MP DAUGHERTY FUNERAL HOME Signatur INTAIN RD. PASADENA MO. 21122 M00942 23a. Part 1. Enter the process, or complications that caused shock, or heart failure. List only one cause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, NSI Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death been signed by the a should be detached I 1 | Yes 2 L 9 | Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown Division of Vital Records, completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate b 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rive Ellicoff City vholet State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Year 6:00 AM Medical Ralph J. Ricketts 30 20 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8177 Mid Haven Road Baltimore Dundal! Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 M 2 F 82 214-26-82 Usual Residence of Dece 8210 Apr 21, 1930 Maryland Pege 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. tent: If Item 27 Is merked other then "neturel", or Items 23e or 28e-f show lury or other traumetic event, the Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 8177 Mid Haven Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ⊠Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph J. Ricketts, Sr Carolina Fredericka Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Jean Ricketts /Wife 8177 Mid Haven Road Dundalk, MD 21222 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State permit. Pege Department i Importent: It eny Injury or Oct 30 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 401443 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DEHENTIA FIVE YEARS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ur. After this certificate has been signed by the attending physician and 9 funeral director, page 2 should be detached for use as the burlel-transit or Attending Physiclen: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 Yes 2 10 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 21 N filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 🗌 Yes 210 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No М Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Mospitel 24 hours a Funerel D To the Hosp within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3340 OCTOBER 30, 201 6x1

Registrar DHMH 17 Rev 06-2011

State

DUNDALK, MD

30. Name and address of passon who completed cause of death (Item 23a) (Type, Print) AVENUT

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Raymond Reddick 6:45 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or BALTIMORE, Examiner City, Town, or Location of Death 4c. County of Death GOODSAMARITAN HOSPITAL MD 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday **Funeral** Birthplace (State or Foreign Country) 1 ☐M 2 ☐ F Director 258-74-6110 Yrs Nov 11, 1947 Usual Residence of Deceder 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ge 1 and 2 should be filed within 72 hours after death with 1 tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e Funeral 6225 York Road 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates Black Completed Specify: 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cement Finisher Mason Local #43 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geneva Summerfield James Reddick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Northwood Drive, Baltimore, MD 21212 Rosalind Reddick 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Oct 29, 2012 Baltimore, Md. Western Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licent Part 1 Inter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a mart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,
Within 24 hours after death,
To the Funeral Director. After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit IMMUNUSUPPRESSION Due to (or as a consequence of): resulting in death) Last Physician/Medical CHEMOTHERAPY IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier shorma, MD 29c. License number 29d. Date signed (Month, Day, Year) REJ 000 10-21-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABMISHEK SHARMA, MD 5601, LOCH RAVENBLVD, BALTIMORE, MD 21239 31. Date filed (Month, Day, Year) NOV 0 2 2012 32. Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service L	ioensee MO14	79		22	. Name ar	nd Addres	s of Facilit	y 1 2	nd Aver	nue	SW (Glen	Burnie,	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDITH M. RIEDER 10 2012 2.33 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death County Homes Assisted Living Harwood Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09/01/1922 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. Director 1 🗆 M 2 🖎 508-14-7170 90 Yrs Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4187 Solomons Island Road 20776 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other to any Injury or other traumatic event, the once. 12 Restaurant Hospitality å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Boling Irma Ribble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Middleton / Daughter 704 Intrepid Way, Davidsonville, MD 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 11/2/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause E for the difficulty Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): igned by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 g 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical l a 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 L No မူ 1 🗌 Yes n 24 hours after death.

The Funeral Director: After this of pletely filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Tyes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martha Ann Russell Medical 10 2012 7:06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/04/1924 Funeral 9. Birthplace (State or Foreign Days Director 1 □ M 2 🗗 F 090-22-2318 87 New York Usual Residence of Decedent or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4710 Bethesda Avenue, #1314 20814 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black. White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Worker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file the ond Mental F should be sho permit. Page 1 and 2 should be Department of Health end Men Important: If Item 27 Is marke any injury or other traumatic. Irvine Russell Martha Davton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis A. Monaghan / POA 6696 Hillandale Road, Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/27/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final CONGESTIVE Onset and Death Physician HEMIT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): ned by the attending physician end a detached for use as the burial-transit The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be o 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law n 124 hours after death. e Funeral Director: After this certificate has t 24a. Was an autopsy 1 Yes 2 A 1 Yes 2 06 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Walursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier c mn

Registrar DHMH 17 Rev 06-2011

State

700

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 0 2 201

1005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Barbara Roppelt 14 am 2.0 october Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Days Hours (Month, Day, Year) 213-38-5733 Director 1 □ M 2 🖾 F July 23, 1940 Maryland ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 313 Hospital Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) filed within Convenience Store Retail Sales other traumatic event, æ aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Adele Prerodd Unknown permit. Page 1 and 2 should Department of Health and M Important: If item 27 Is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry K. Dodson / Son 212 Cherrydell Rd., Catonsville, Maryland 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 20129, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. Catonsville, Maryland 4 Denation 5 Other (Specify) 21. Signature of Franci Servi Licens rkiey-Ruddick Funeral Home, P.A. I Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ne minule disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (unas a consequence of sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No a I I Inknown 9 Unknown Part II. Other significant conditions contributing to pleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 No Kidne: 1 Yes 2 No Was case referred t medica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: |@ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital of 24 hours at Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, per 1h, g933 11-2-12 sm State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2012 CAROLYN STEIN ROSENSTEIN 8:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3316 WOODVALLEY DRIVE BALTIMORE BALTIMORE **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 151-30-8385 Director 1 - M 2 X F 75 05/24/1937 N.T Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 😿 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3316 WOODVALLEY DRIVE 21208 USA death v "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 XMarried should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event: the Me College (1-4 or 5+) 5+ Elementary/Secondary (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ I. JOSEPH STEIN HILDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 BERYL ROSENSTEIN/HUSBAND 3316 WOODVALLEY DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/1/2012 1 ABurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) BETH EL MEMORIAL PK 10/31/2012 RANDALLSTOWN, MD e of Fyneral Se . Sk 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Enter the disease, or corpo cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ metastahic pancrealic cancel disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Physician: The law requires that the death certificate be Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ģ Pregnant at time of death 5 Other (specify) Month Day Year detached 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sempletely filled in by the funeral director, page 2. autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, Manner of Danth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending 1 Natural iniury Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one) 29d. Date signed (Month, Day, Year)

State Registr<u>ar</u> D53070

Promymog Ralhmore, MD 21287

there, M.D

address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orkans St

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3	Removal from State		emetery	Disposition (if crematory of CEN	or other place	;e) 11/	Date /2/2012	1	Location - City TIMORE		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 (Check 2	Certifying Ph Medical Exar	ysician: To the best of niner: On the basis of e	my know xaminatio	ledge, den	eath occured investigation	at the time, in my opinio	, date and place, a on, death occurred	and due to the ca at the time, date	ause(s) a and plac	and manner as	stated. e cause	(s) and manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 201^{Year} Day Physician/ Jacqueline Thelma Shearer 4:37 P October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Clarksville 6939 Westcott Place 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** (Month, Day, Year) Director 215-29-0659 1 🗌 M 2 🗶 F June 17, 1990 Maryland Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State the Maryland Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Clarksville Maryland Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. Page 1 and 2 should be filed within 72 hours after death with 21029 6939 Westcott Place 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 X Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Student Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 7 is marked o မ Barbara Campbell Danny Shearer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health 6939 Westcott Place Clarksville, Maryland 21029 (Father) Danny Shearer 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date o = o cemetery, crematory or other place, 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 11-1-2012 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee M 01050 K. Haden Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CEREBELL COMPRESSION Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PROGRESSIVE BRAIN Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or injury PENDYMO the Hospital or Attending Physician; The law requires that the death certificate be executed ANAPIASTIC and -trar that initiated events Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No should be detached for Month 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner?
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Suicide after death. the Investigation within 24 hours after dea

To the Funeral Director

completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHIGAN AVE NU 32. Registrary Signature

RAUD

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D005558 29d. Date signed (Month, Day, Year)

WASHNITON

29/2012

20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 29, 2012 Josephine (nmn) Stamper 8:38 p M Medical 4a. Facility Name (if not institution, give street and number)
2723 Creswell Road **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours 239-50-8025 **Director** 1 M 2X F 74 31, 1937 North Carolina Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location ural", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2723 Creswell Road 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates White Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the 12 Kitchen Aide Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ James Frank Billings Bessie Mae Billings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Tonya Boynton / Daughter <u>3772 Peach Orchard Rd., Street, MD 21154</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 11-3-12 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Chroniz Obstructive money Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes Yes 2 N or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: ompletely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the policy of the cause (s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) rumn

DHMH 17 Rev 06-2011

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State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year

2 2012

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 4 Physician/ Smith Lee Howard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1800 Hollins Street Apt.#301-F Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min. 220-40-9187 69 Director 1 **X** XM 2 □ F 01-13-43 Usual Residence of Decedent or then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location deeth with the Merylend 10d. Inside City Limits Director 1 Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Hollins Street Apt.#301-E USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African ģ 1 Never Married 2 Married within 72 hours efter Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed Specify: American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pege 1 and 2 should be filled within 72 h Depertment of Health and Mental Hyglene. Important: if item 27 is merked other then "ne eny injury or other treumetic event, the Media 20106. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Scrap & Metal 10th Grade NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bell Bessie Martin Madison Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Pittston Circle Owings Mills, Maryland 21117 Eva M. Cortes-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Zion Cemetery 1 X Burial 2 Cremation 3 Removal from State 11-01-12 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying ours after deeth.

Prefector: After this certificate has been signed by the ettending physician end filled in by the funerel director: page 2 should be deteched for use as the burial-transit. Exami Cause (Disease or injury that initiated events Hospitei or Attending Physicien: The lew requires thet the deeth certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 10/25/12 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2√2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2N 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner:
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 0 2 2012 32. Registrar's Signature State Registrar

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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examinar must be notified at once.		1 Burial 2		3 Removal from	State	cemetery, c	rematory o	r other plac			/2012	200.		tsvi1		MTD
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	the lithin 2 the lomple	ğ	only one) 29b. Signature and	3 ☐ Certifying	Nurse Practitione	r: To the best of	my knowled	ge, death o	ccurred at t	he time, da	ite and pla	ce, and due to	the caus	se(s) and m	anner as s	tated.	
	` 		So. Orginature and	/ A	11			2	9c. License		7			ate signed			
			30. Name and add	ress of person	ho completed cau	se of death (Ite	m 23a) (Tvn-	. Print)		947			VU	DBER OM	1311	29	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month 1707 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Howard **Howard County General Hospital** 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Days 27 (Month, Day, Year, Director None 0 MD Oct 22, 2012 Usual Residence of Decedent 28a-f shov 10a, State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Oxon Hill Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2203 Owens Road 20745 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Shervell M. Stevenson Kristen S. Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is I Shervell . Stevenson 2203 Owens Road Oxon Hill, MD 20745 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State y, crematory or other place) 4 Donation 5 D Other (Specify) Oct 26, 2012 Catonsville, Maryland Metro Crematory, Inc. 21. Sign ____ neral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Ent. It e disease, or complications that caused the death shock, or he rt failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) the detached g Unknown g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 🗌 Probably 4 🔲 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 2 No ___Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

24 hours after death. Funeral Director: After this

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nia Jewell Leak Howard County General Hospital Columbia, MD 21046 31. Date filed (M 32. Registrar's Sign ture

State Registrar 29b. Signature and title

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 011ie Smith 11:04 a^M October 0 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester Chesapeake Wood Nursing Center Cambridge Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ XF Months Days Hours 212-36**-**1911 Director VA 1920 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State PA York Hanover 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17331 29 Loop Drive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 □Yes 2 TNo If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nursing assistant health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Ly Important: If item 27 Is marked oth any linjury or other traumatic event once. Nora Boyd Abe Barton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Crawford (daughter) 29 Loop Dr., Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 11-2-12 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive neart **Physician** ULICAUS /Medical Due to (or s a consequence of): Examiner sten MC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Mo or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

100 Bramble St, Cambridge MP

30. Name any arress of person who completed cause of death (Item 23a) (Type, Print)

Johnson

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 20 John 117 AM Harry stei Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore It u HOPKINS HOSPITA Johns 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 218-28-1796 Director 1 M 2 □ F Usual Residence of Decede show and Mental Hygiene.
and Mental Hygiene.
is marked other than "neturel", or items 23a or 28a-f shov
is marked other than "neturel", or items 23a or 28a-f shov
raumetic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director BAITIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street Funeral 21202 Stiles U.5-A within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify Year or Dates. A 16 Force Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1:4 or 5+) Sterneship Be permit. Page 1 end 2 should be filed. Department of Health and Mental Himportant: If item 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (SENCYIEVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEANOR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗋 Cremation 3 🗆 Removal from State 11-5-2012 BA cey 4 Donation 5 Other (Specify) DAKLAWN Funeral Service Lice NZA Jos.ph 22. Name and Address of Facility 21. Signatu CONKling 5+ BA/40 23a. Part 1. Enter the disease, or plinitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only Immediate Cause (Final Transitional cell) Metastatic Urothelial Physician Carcinom disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Year 1 Yes 2 L 9 Unknown director, page 2 should be detached g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director. After this certificate has completely filled in by the funeral director, page 2: performed 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the P Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) salto MO State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 1307 M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Funeral** 4 Hrs Min. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Year Hours Country) Director 1 **X**M 2 □ F 67 8/7/45 MD show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD N/A Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1616 E. Clement Street 21230 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner ŏ Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural". White Specify Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the 9 0 Longshoreman Shipping Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Paul R. Smith, Sr. ပ Amelia R. Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tra Pamela C. Smith / Daughter 1616 E. Clement Street, Baltimore MD 21230 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cremation Center of ND 10/4/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: 11 any injury or Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc $O_1 O_2$ 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nemorch disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** guamou Sequentially list conditions, Limita lases a consequence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Pregnant at time of death Year be detached the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown plnous peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 has autopsy performed? Yes 2 No certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 | No ည 1 Inpatient 2 ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation 6 Could not be the Accident Suicide 3 □ Suiciae 4 □ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 260 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore aura mpo Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 06-2011

NOV 0_2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 400pm rmah 201 Medical 4a. Facility Name (if not institution give street and number) Town, or Location of Death **Examiner** Canda 1151 · Ula ′୧ RUT 0.0 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 212-28-3290 1 X M 2 □ F 88 10/08/1924 MD ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1029 SCOTTS HILL DRIVE 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) EXECUTIVE LIFE INSURANCE Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill timent of Health and Mental tant. If item 27 is marked o 2 WILLIAM SAMUEL CARRYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD SAMUEL/SON 230 HOMEVALE ROAD, REISTERSTOWN, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 11/08/2012 OWINGS MILLS, MD Signature of Funeral Service Issues 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Q disease or condition resulting in death) Medical Durate (or as a consequence of): Examiner 0 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (1) e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant : 9 Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Manper of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28d. Describe how injury occurred 107 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifier 30,2012 38 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 06-2011

			_ For	State of	Marylar	nd / Depa	artment o	of He	ealth a	and M	lental Hy	giene		
			State Registrar			Cer	tificate d	of De	eath		-	Reg. No. 2	012	35134
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and !	Examir		4a. Facility Name (if not institution,	give street and number) ~		4b. City, Tov	vn, or L	ocation of	f Death			ounty of Death	10000
			BALTIMORE WASHING		AL C	ENTER	G	LEN	1 3	URN	IE	AN	NE AR	UNDEL
	Funeral				Age (In yrs.	last birthday)	If Under 1 Y		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		218-42-2330	1 X ∃M 2□F	68	Yrs.	Wilding D	,,,,	TIOGIS		06/06/		Mary	* *
	how at	٦	Usual Residence of Decedent 10a. State 10b. County			ity, Town or Loc	ation							0d. Inside City Limits
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	with t	sra	216 Olde Point	lane				2165	58				.S.A.	ury !
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho tthe Medical Examiner must be notified at	Funeral Director	11. Marital Status	12 Was Deceder	it Ever in U.	.S. 13. V				in? (Spec	cify Yes or No-		Race - Americ	an Indian
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Maryland	nd 2 should be filed within 72 hours salth and Mental Hyglene. n 27 is marked other than "natura er traumatic event, the Medical E.		19a. Informant's Name/Relationshi Bonnie Lee Summe			- 1							vn, State, Zip C ryland	*
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Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of) Funeral Service Lice			lantic								Maryland
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Вох	atter for u	cial	in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant	2 Feta	al death 3	Ectopic pregi	nancy				23d	. Date of delive Month	ry Day Year
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orc	v requires s been sig	olet									24a. Was	an 2	4b. Were autop	sy findings available
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying P	Physician: To the best of aminer: On the basis of	of my know	ledge, death or	courred at the	time, d	late and pl	lace, and	due to the ca	ause(s) and m	nanner as state	d.
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0			30. Name and address of person wh		death (Item	23a) (Type, Pri	nt)							18,2012
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 29,2012 Year 8:15 A. M KATHERINE TRIMBLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO. PERRY HALL 9917 PEPPER HILL ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Security Number Funeral Days (Month, Day, Year) 220-18-4258 Director 1 M 2 X 85 MARYLAND 12-4-1926 Usual Residence of Decedent show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director PERRY HALL BALTO. 1 Yes X No MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21128 9917 PEPPER HILL ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) ASSISTANT MANAGER Elementary/Secondary (0-12) College (1-4 or 5+) LIFE INSURANCE CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JENNIE CASCIO JOSEPH G. MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11202 CEDAR LANE KINGSVILLE, MD. 21087 19a. Informant's Name/Relationship (Type, Print) BRO. JOSEPH A. MARTIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State TIMONIUM, MD. 4 Donation 5 Nother (Specify) ENTOMBMENTDULANEY VALLEY 11-2-2012 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Li 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPAT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ORONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical

s after death. within 24 hours a

To the Funeral C

completely filled

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36630 31 201 our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m01 Churles 1000 (West Pavi)in

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

31. Date filed (Month, Day, Year) NOV O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Marylar		tificate of D		_	Reg. No. 2	2 35137			
Physic	ian/	Decedent's Name (First, Middle, La. John J		Tes	orero, Ji	r.	2. Date of Dea	ath r 22, 201	3. Time of Death 2 11:15 P M			
Med Exam	lical iner	4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death	1 000000	4c. County of E	Death			
أموس		Manor Care Potoma 5. Social Security Number 6. S		last birthdav)	Potomac If Under 1 Year	If Under 24 Hrs.	8. Date of Birl	Montgo:	mery Birthplace (State or Foreign			
Funera Directo	_	028-05-1940	XM2□F 91	Yrs.	Months Days	Hours Min.	Nov • 30	y, 1920 Bc	ston, MA			
and Show	٥	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits			
Maryl 28a-f notified	Director	CT Hartfor	d Ro	cky Hi					1 X Yes 2 □ No			
with the 23a or ist be r	eral			,	10f. Zip Code 06067			10g. Citizen of Wha U.S.A.	t Country?			
death r ritems	Funeral		12. Was Decedent Ever in U. Arged Forces?	S. 13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.			
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15-0 72 hou n "natu fedical	nplet	15. Decedent's E (Specify only highest gi	ade completed)	(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation Juring most of work	ing	16b. Kind of Busin	ess Industry			
212 within rgiene.	Cor		College (1-4 or 5+)		Preside	nt		Adverti	sing			
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle, Last) John J. Tesorero	, Sr.			18. Mother's Nam Elizabe		Maiden Surname) ontușo				
Maryland Should be filed v h and Mental Hyg T is marked othe		19a. Informant's Name/Relationship (Type, Print)	1.0	•			er, City or Town, State				
e, M and 2 s Health tem 27		Mary Ellen Roger: 20a. Method of Disposition			Stone M		Oakton Date	, VA 22124				
imor Page 1 ment of ant: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Spec	Removal from State	cemetery, crem	natory or other plac	ry 10/2		Boston,	·			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	olice,	21. Sign sure of F meral Service Licen	Muu	²² M	Name and Address	ss of Facility tan Funer St., Ale	ral Serv	vice 1, VA 2231	0			
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea		r the mode of dying	g, such as cardiac	or respiratory ar		Approximate Interval Between			
- Enypiciar Medic	_	Immediate Cause (Final disease or condition resulting in death) The TASTATIC PROSTATE CA. Due to (or as a consequence of):										
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pa tisi	Examiner	Sequer flam list on officine, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Sequer flam list on officine, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): FAILURE TO THRIVE.										
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68 Se a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	al death 3 🗆		; ;		23d. Date o				
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death or stree death. Its after death. al Director: After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for un	Physician/N	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 L	Other (specify)			Month Day Year				
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ords require been s	Completed						24a. Was	an 24b. Wer	e autopsy findings available			
Reco	Somp						auto perfo 1 \square Yes	ormed? dea	r to completion of cause of th? Yes 2 No			
Vital Rec hysician: The lar his certificate ha Il director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ace of Death (Chec						
of V ig Phys ter this neral di	te: To	07. Marriage (Day 1)	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	at 3 🗀 DOA 28c. Injun	y at		dence 6 Other (S	Specify)			
ttendir death. stor: Aff	Certificate	1	on De 290 Place of Injuny - At h		M 1 🗆	Yes 2 ☐ No	28f Location /	Street and Number o	r Rural Route Number,			
Divis			building, etc. (Special		oct, lastory, smos		City or To)			
Division of Vital Records, P.O. I to the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of my knowniner: On the basis of examinations of examinations of the best of n	on and/or invest	igation, in my opinio	on, death occurred a	at the time, date	and place, and due to	the cause(s) and manner stated.			
To the To the Comp	_	29b. Signature and title of certifier			29c. License		_	29d. Date signed (N	fonth, Day, Year)			
0,		30. Name and address of person who		m 23a) (Type, F		7 7 7 7 7		10/23/	7 ∞ .			
\		Pinky S. Singh			nsin Ave.	., Bethes	da, MD	20814				
S Regis	tate trar		32. Registrar's Sign		back							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 28, 2012 Рм 3:15 Catherine Thomas Marv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 577-54-7391 Director August 31, 1939 Yrs Washington, D.C. Usual Residence of Deced ba filed within 72 mountenants and the state of 28a-1 encourts at a control of the state of the 10d. Inside City Limits 10a State 10c. City. Town or Location Director 1 Tes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20854 7816 Horseshoe Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White, etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)
Computer Technology
Administrator (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) Department of Energy 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of ဨ should ba Rose Marie Buonviri Anthony Joseph Vammino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pega 1 and 2 sh ment of Heelth a tent: If item 27 is 7816 Horseshoe Lane, Potomac, Maryland 20854 Lloyd A. Thomas / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Pega Depertment of Importent: If eny injury or once. ö Gate of Heaven Cemetery Silver Spring, Maryland 2012 5, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22.Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 20850-2805 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rrhythmia Physician/ Mali nant nihules disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Ovarian Sequentially list conditions, Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury • Hospitel or Attanding Physician: The lew requires that the deeth cartificata be executed 24 hours eftar death.
• I Funerel Diractor: After this certificate has been signed by the ettending physiclen end letely filled in by the funeral director, page 2 should be detached for use as the burlel-trensite. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To tha Funer

completely file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) OCtober 5802 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville MD 10 Wenk Johathan 32. State Registrar

DHMH 17 Rev 06-2011

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		4	State of Maryla	-			lental Hygie	ene			
			Registrar 1. Decedent's Name (First_Middle_Last)	Cer	tificate of D	eatn	Reg. No. 2 3. Time of Death				
	Physicia Medic	n/	Nancy Tarbutton				000 23 2012 6:19 PM				
	Examin		4a. Facility Name (Ir not institution, give street and number) 1435 Andre Street		4b. City, Town, or	Location of Death Baltimore)	eath N/A			
	Funeral Director		214-56-7492 1 □ M 2 XX 62	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 6/8/5	(ear) 9. (Birthplace (State or Foreign Country) MD		
	and show	ro		City, Town or Loc		Gi bu	-		10d. Inside City Limits		
	e Maryler 28a-f	Director	MD N/A 10e. Street and Number		10f. Zip Code	more City		g. Citizen of What	1 Yes 2 No		
	with the	Funeral I	1435 Andre Street		101. 2:p Code	2123		g, Citizen of What	USA		
36	after death	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates	l I	Was Decedent of Hi f Yes, specify Cuba □ Yes XX No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White		
8	hours inatura dical E	olete	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation	ina 1	6b. Kind of Busine	siness/Industry		
121	thin 72 ene. than " he Med	3 K Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. Specify.									
Baltimore, Maryland 21215-0036	be filed wi ental Hygia rked other ic event, t	00	12 0 17. Father's Name (First, Middle, Last) Harry Showalter								
Mary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Michael V. Tarbutton /Son	Zip Code) 21230							
imore,			20a. Method of Disposition 1 Burial	or Town, State Maryland							
Balt	permit. Departr Import. any inji	1301 E. FOIL Ave., Baltimore Fib 2									
			23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final	eath. Do not ente			or respiratory arres	t,	Approximate Interval Between Onset and Death		
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	ate be executed hysician and the burial-transit	dical Examine	resulting in death) Last Due to (or as a conse	equence of):							
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Box 687	Physician: The law requires that the death certifica this certificate has been signed by the attending pland director, page 2 should be detached for use as the state of the control of the control of the certification is a second of the control of the certification of the certificat	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	23d. Date of Month	f delivery Day Year						
Division of Vital Records, P.O.	law requires that the dea has been signed by the a je 2 should be detached	Š	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause gi	ven in Part I.			e to the cause of death? Probably 4 Unknown		
Record	The law requate has been bage 2 shou	Completed					24a. Was an autops perform	prior ned? prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No		
ital	ician: certifica rector.	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Oth	ace of Death (Chec					
n of V	iding Phys th. After this funeral di	cate: To	1	28b. Time o	of 28c. Injur	y at	ome 5 Reside 28d. Describe how		ресіту)		
Divisio	al or Attending s after death. I Director: After id in by the fune	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe		reet, factory, office		28f. Location (Str City or Town		Rural Route Number,		
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	Medical	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only one) 3 Certifying Nurse Practitioner: To the best	ation and/or inves	stigation, in my opini	on, death occurred	at the time, date and	d place, and due to	the cause(s) and manner stated.		
	To the		29b. Signature and title of certifier	m	29c. Licens	e number	2	Oct 7	Ionth, Day, Year)		
7	, 		30. Name and address of person who completed cause of death (I	tem 239) (Type,	Print) Lin	Blud	akn	Buzar	0 21061		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	petut							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Deformer 7:45 AM Physician/ Theodore O. Thompson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 395-20-7304 Director 1 🙀 M 2 🗆 F Aug. 27, 1927 Wisconcin Usual Residence of Decede 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 🗌 Yes 2 🙀 No Maryland | Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21146 United States 302 Hollyberry Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Korea 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Freida Schwant Theodore O. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 Hollyberry Rd., Severna Park, Maryland 21146 Carolyn F. Thompson / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-5-2012 Crownsville, Maryland Crownsville MD Vet. Cem. 5 Other (Specify) Donation 22 Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 21. Signatu of Fineral Service Lice see MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OVI 6 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) ed by the at detached for 9 signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred funeral Certificate: Natural : After t iniurv 5 Pending s after death. Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractitioner To the best of my thomas and the state of the cause state o (Check 29b. Signature and title of certifie 29c. License number son who completed cause of death Mame and address Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

12-08075 James Utley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Time of Death Pecedent's Name (First, Middle I ast) Physician/ Month Day October 24, 2012 2340 hrs Medical Examiner ames 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD Months Days Hours Min. Director 9060 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore Yes 2 No 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral Was Decedent Ever in U.S. Never Married Yes Specify: Block 2 No specify: 4 Divorced If Yes, Give Year 3 Widowed 6 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 ever Worked 18.Mother's Name (First, Middle, MICKO Nannette Rural Route Number, ty or Town, State, Zip Code) 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (T pe, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name crematory or other place) Cremation 3 Removal from State Metro Cremator Donation 5 Other Specify 270 Fredhilton Pass Soute MD 22 Name and Address of Facility Approximate Interval Lenger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown isigned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an certificate has been the funeral director, page 2 should prior to completion of cause of autopsy death? performed? 2 No ✔ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Subject shot Certification: Oct 24, 2012 2302 hrs Natural 1 Yes 2 ✔ No 5 Pending Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1400 East Preston Street, Baltimore, Md determined (Specify) Sidewalk 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 25, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

Zabiullah Ali, M.D.

32. Registrar's Signature

ORIGINAL

OGME

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 130A WARCZYNSK 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 💢 M 2 🗆 F Months Hours MARYLAND **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at with the Maryland Funeral Director MY 1 Yes 2 No KESVILLE 10e. Street and Number 10g. Citizen of What Country? 217 USA 7200 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Ves 2 No P42If Yes, Give
Year or Dates. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Divorced 4 Divorced Completed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) ESTERN OREMAN Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) th and Mental H
27 is marked ot
traumatic ever ပ WARCZYNSKI 19a. Informant's Name/Relationship (Type, Print), 800THEC-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau PARSLEY OR IN-LAW TIROCCHI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State LONDAINE PARK CEM 12012 WOODLAWN, MO 4 Donation 5 A Other (Specify) ENTOMISMENT 22. Name and Address of Facility) N Zumaww)-H 4 mov Co Signature of Funeral Service Licensee 21784 ELDERS BURG- MO 6026 SYKESVILLE RO 23a Jal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the at d be detached for a 🖂 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2, No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hin 24 hours after death.

the Funeral Director; After this npleted filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation injury 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🞾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cerptying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one

State Registrar

31. Date filed (Month, Day, Year) NOV 0 2

29b. Signature and title o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 45 Liberty Rd Elevs bur 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20c, perffl, G933, 11/7/2012, WS
State of Maryland / Department of Health and Mental Hygiene
amend #5 Per FH G933 11/14/2012 Jh

Certificate of Death

Reg. No. 2 0 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 26, 2012 MARIE MULLERO 2:00P M ANNE. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore City 6100 Everall Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 50919 5951178 54710 Funeral Hours Director 1 M 2 X F 75 Dec 19, 1935 Washington, DC Usual Residence of Decedent in than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 X Yes 2 No N/A Baltimore City Macyland 10e. Street and Number 10g. Citizen of What Country? 21206 USA Funera 6100 Everall Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes Give Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. City of Albany, Elementary/Secondary (0-12) College (1-4 or 5+) New York Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H is marked of Department of Health and Mental Important: If Item 27 Is many in Jury or other 2 Anne Rosalie Kerfoot William Hacold Millerd, Sc. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5704 Roland Avenue, Baltimore, Maryland 21210 Rev. William H. Millerd, Jr., SJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State
Baltimore, Maryland Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Inc. 11/8/2012 Silver Spring, MD Metro Crematory. 21. Signal of Fundal Say Celicer MITCHELL WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
YCACS Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Tobacco use history veacs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (5r as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
• Funeral Director. After this certificate has been signed by the ettending physician and letely filled in by the funeral director, page 2 should be deteched for use as the burlel-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Atrial fibrillation, chronic kidney disease, 1 ¥ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Pulmonacy hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical å 26. Place of Death (Check onfy one) examiner? Other: 4 \(\subseteq \text{Nursing Home } 5 \) Residence 6 \(\subseteq \text{Other (Specify)} \) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 3 Suicide 5 🗌 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00065145 Olekan 31-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 412, 5601 Loch Raven Blvd. Baltimore, Macyland 21239 Olga Luyre, M.D., 31. Date filed (Month, Day, Year) NOV 0 2 2012 egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 2 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 5:45 P M October 1 Prentice Rodger Whitman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Sommerford Assisted Living If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**X** M 2 □ F Director 310-14-0420 Usual Residence of Decedent Yrs August 6,1921 Indiana 91 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County notified at 10a. State North Director 1 🗌 Yes 2 🏝 No Elm City Carolina Nash 10f Zip Code 10g Citizen of What Country? 10e. Street and Numbe 'n th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i Completed by Funeral with 1 U.S.A. 27822 9739 Highway 58 S permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 No
If Yes, Give
Year or Dates. Marines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) National Security Agency Purchasing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Elizabeth Willis George Prentice Whitman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dayton, Maryland 21036 14010 Triadelphia Mill Road Chervl Beall (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State At intic Crematory or other place!

Meadowridge Memorial Park Glen Burnie Md. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-25-2012 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Lice Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death emention Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): burial-t resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
9 Unknown Month Year in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSI Ho Livi 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No death. Investigation 6 Could not be Director: A Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29b. Signature and title of certifie m 28 2012 WI empleted cause of death (Item 23a) (Type, Print) 30. Name and address of gerson Andrew Laris, M.D. 6334 Cedar Lane #103 Columbia, Maryland 21044 NOV 0 2 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. arver Webster Medical 4a. Façility Name (if not institution, give street and number) 4b. City, Town or Location of De 4c. County of Death Examiner *eci* 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Months Hours (Month, Day, Year) Country) 726-10-1152 Director 1 M 2 □ F New York 80 July 10, 1932 and 2 should be filed within 72 hours after death with the Maryland F Haaith and Mantal Hygiana. It has the same says or 28e-f show ther traumetic event, the Modical Exercity must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Harford Edgewood 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21040 USA 611 Boxelder Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Medical Photographer U.S. Government 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adavene (unk) Moore James Harvey Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 611 Boxelder Drive, Edgewood, Maryland 21040 Carolyn A. Webster / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Dapertmant of F
Importent: If ite
eny injury or ott 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2012 Owings Mills, MD 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart halidre. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Prysician Medical resulting in death) Due to (or as a consequence of): Maminer SEVENC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the daath certificate be axecuted ata has baan signed by the attanding physicien and pega 2 should ba datached for use as tha burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DROBETH MELLOTUS 24a. Was an autopsy performed? Yes 2 Aftar this cartificata 1 ☐ Yes 2 ☐ No funaral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending death. 1 ☐ Yes 2 ☐ No tha Investigation **Director:** 6 Could not be within 24 hours after des To the Funerei Director complately fillad in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 0020390 npleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month. Dav. Year)

32. Registrar's Signa

tealth Care System

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ameron whiten		1- For State Criticate of Dea		Reg	201	2 35 14
Physicia	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami ~	ner	Cameron Nathaniel Wharton		Month Cotober 26,		1840 hrs
			r, Town, or Location of D jewood	eath	4c. County of Death Harford	1
Funeral			nder 1 Year If Under 2		(MM/DD/YYYY) 9. Bir	
Director		219-77-9937 1 N M 2 F 5 Yrs. Mon	nths Days Hours	Mar. 22	2, 2007 Foreign	untry) Maryland
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show	5	Maryland Harford Edgewood				1 Yes 2 No
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f she fraumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Pu			can Indian, Black,
ter dez ", or i		1 Yes 2 X No	2X No specify:		Specify: Bla	ack
ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua	al Occupation (Give kind		6b. Kind of Business/I	
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21 be file antal H urked	Be	Harry Eugene Wharton		a Shanell		
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than natic event, the Medical	٩		ss (Street and Number			
		20a. Method of Disposition 20b. Place of Disposition (N			20c. Location - City or	
MOFE Pages 1 tent of H tent iffi tr other		1 Burial 2 Gremation 3 Removal from State crematory or other place Rose Hill Sv.		1/2/2012	Bel Air,	Maryland
Baltimore, permit. Pages I an Department of Her Important: If ite	ì	4 Difficulty Specify.	nd Address of Facility		Funeral Ho	
	d	Morth (hory) 1317	Cokesbury F	Road, Abing	don, Maryl	and 21009
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Examiner		Immediate Cause (Final disease or condition resulting in death) a. Smoke and soot inhalation in death) Due to (or as a consequence of):	מי			Death
*		Sequentially list conditions, b				
	miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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Division of Vital Records, rail or Attending Physician: The law requirated or Attending Physician: The law requiral princed or After this certificate has been seled in by the funeral director, page 2 should	Completed			performe	ed? death?	
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/iSiC ir Atte ter dea irecto	Certification:	Accident Accident	ry, office building, etc.	28f. Location (Stro	eet and Number or Ru	ral Route Number, City Lestown Dr.
DIVI pital or ours afte teral Dir filled in	Series	4 Homicide determined (Specify) found in house	<u> </u>	or Town, State		restown Dr.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the one) 2 Medical Examiner; On the basis of examination and/or investigation, in n				
T will	Me	and manner stated. 29b. Signature and title of certifier	9c. License number	2	29d. Date signed (Mor	nth, Day, Year)
		Potri On- Hollon_	O.C.M.E.	•	October 27, 2012	2
\emptyset		Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD	V. Baltimore Stree	t. Baltimore MD	21223	
<u>[</u>	ate	31. Profiled Math. (Par.) 32. Register's Signature		i, baitanore, MD		
Regist		MUY U & CUIL LENGTH D. MANAGE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical give street ar **Examiner** or Location of Death **Funeral** 8 Date of Birth (Month, Day, Year)
Oct 01, Months Min Country) Pennsylvania Director 93 188-12-0977 1 XM 2 □ F 1919 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Stevenson 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7722 Wynbrook Road 21153 United States "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes f Yes, Giv within 72 hours after 2 No Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene, item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Glenn L. Martins Quality Control Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Granville Werley Libby Bachman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Werley /Son Page 1 and 2 Stevenson, MD 21153 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Oct 30 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Narce and Address of Facility Funeral Alternatives Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death Day Year signed by the a 2 [q Unknown 9 Unknow Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of page performed death? Division of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier person who completed cause of death (Item 28 (Type, Print 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 1.4 ridae 20 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Hmore 5 Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months Director 1 2 □ F 49 1962 213-84 -9407 Dec 10, Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1. Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 525 South Kenwood Avenue United States 21224 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ρ 1- Never Married 2 ☐ Married Yes 2 No 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nick's Seafood Cook Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Unk Unk Phyllis Woolridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Rivard /Partner 525 South Kenwood Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct 31 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives MOI Croon Pactures Drive Towson Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to is ical Be 26. Place of Death (Check only one) examiner? 2 4 No Hospital Other: ၉ 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred U Natural
☐ Accident
☐ Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOFPH YAM, MO 1800 Orleans 31. Date filed (Moot 2 2012 State 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Farl White October 28 2012 1:35a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Hospice Dove House Carrol1 Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 215-32-5510 Director 1 M 2 □ F Apr 28 1935 MD Usual Residence of Deceder "naturai", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Eldersburg 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 5732 Greenville Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 0 5 7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Types 2 No 1957— Black White etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 x No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) electrician electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health end Mental H fitem 27 is marked of James White Genevieve Snyder Page 1 and 2 should be traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol White (spouse) 5732 Greenville Rd., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once. Separtment of cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) 11-1-12 Finksburg, MD Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Paralyaught 2 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury l or Attending Physician: ווש ומנה בים בים בים היום אישה של After this certificate has been signed by the attending physician and increased for use as the burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 2 🗆 No ☐ Yes 1 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Certificate: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe who completed cause of death (Item 23a) (Type, Print) D 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCAOGE - 30, 2012 216 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Randa 11stown 403 7:11:MOIR exter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours 215-34-5192 75 Director 1 X M 2 □ F Jan 17 1937 MD item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Sykesville Carroll 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funeral 21784 1248 Pouder Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Howard Co. Government planner Be permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leslie Clair Waddell Sr. Anna Helen Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1248 Pouder Rd., Sykesville, MD 21784 Mrs. Marilynn Waddell (spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-5-12 Sykesville, MD Lake View Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME Paige Vaight P.O. BOX 195 SYKESVILLE, Md. 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) reprove Medical Examiner Sequentially list conditions, if any handing to immediate cause. Enter Underlying Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physiclan: The law in within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s completely filled in by the funeral director page 2 s autopsy prior to completion of cause of death? death? **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Acciden 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of depth (Item 23a) (Type, Print) VΟ 31. Date filed (Month, Day, Year) 62. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTON LINDA LEE WICKS :34 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-50-9710 Director 1 M 2 XF 65 Jan 30, 1947 Maryland 1 4 1 27 is marked other then "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Anne Arundel 1 Yes 2 X No Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1403 Peace Drive 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Š 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "rany Injury or other traumatic event, the Med ODGE. Elementary/Secondary (0-12) College (1-4 or 5+) University of Maryland at Baltimore Payrol1 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ William Scott Naomi Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Lynn Wicks (Husband) 1403 Peace Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Atlantic Crematory, LLC 4 ☐ Donation 5 ☐ Other (Specify) 10/29/12 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 MOO175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition week Medical resulting in death) Due to (or as a consequence of) Examiner DIRC 10 clears Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine a nunsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use es the burial-trensit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part JL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License numbe ovacu 00068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 32. Registrar's Sgnature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\text{Yea}}{12}$ Gerard A. Zulli October 4:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) 197-18-1650 87 Director 1 K M 2 □ F June 7, 1925 Pennsylvania I Hygiene. other than "neture!" or Items 23e or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours efter death with the Merylend 10c. City, Town or Location 10d. Inside City Limits Director Maryland Potomac 1 🗌 Yes 2 🔯 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 20854 10918 Candlelight Lane United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Accounting permit. Page 1 and 2 should be filed Depertment of Health and Mental Hyg Important: If Item 27 is marked other yellows. other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Zulli Angelina Novelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Zulli/Wife 10918 Candlelight Lane, Potomac, Maryland 20854 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Saints Peter & Paul Cemetery Springfield, Pennsylvania 1 Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundal Survey Licensee Bethesda-Chevy Chase, Inc. ryland 20814-3501 22.Name and Address of Facility Robert A. Pumphrey Funeral Home/ M00198 <u>7557 Wisconsin Ave., Bethesda,</u> Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure to Thrive resulting in death) Medical Due to (or as a consequence of) Examiner Senile Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Due to for as a consequence of Exam or Attending Physicien; The lew requires thet the deeth certificate be executed for use es the burlel-trensi signed by the ettending physicien end id be deteched for use see the board in that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been significate has been significated and a should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves 2 🔀 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🖾 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) mas D50534 October 31, 2012

State Registrar

DHMH 17 Rev 06-2011

6801 Whittier Avenue #205, McLean, Virginia

22101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

Thomas Masterson, M.D.

NOVO

31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gober 2012 Wilbert Herman _Anderson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday **Director** 207-16-9552 Usual Residence of Deceden 1 XM 2 - F 85 8/16/1927 PA items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 \ No Mc Connellsburg Fulton 10e. Street and Number 10g. Citizen of What Country? Funeral 6974 17233 Cito Rd USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Truck Driver Hamil Express Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e Herman Anderson Elna Elstrum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn A. Miller (Daughter) 6974 Cito Rd. McConnellsburg, Pa. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GeiselFun.Home 10/17/2012 Chambersburg, Pa. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Howard L. Sipes Funeral Home Way E. McConnellsburg.Pa.17233 Lally Lincoln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final disease or condition Physician/ ENMONI Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last CULCULU Due in or as a consequence of): Accident Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò To the Hospital or Attending Physician: The law requires I within 24 hours after death.
To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **A** No ᅆ 1 ♀ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JW-しゅ State

Registrar

DHMH 17 Rev 06-2011

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Patsy Williamso		1- For State Registrar		of Marylan		artment o rtificate o			Mental	Hygi		g. No. 20	112	3515
Physicia Medical Exami			ne (First, Middle,Las Ltsy Willi		bers					N	Date of Deat Month October 12	Day Yea	ar	3. Time of Death 0850 hrs
		4a. Facility Name 1647 Town	(if not institution, giv point Road	e street and numb	er)		4b. City, To Chesa	wn, or Lo peake (eath		4c. County Cecil	of Death	
Funeral Director		5. Social Security 229–38– 0		7. M 2 7.	Age (In yrs. I 76	ast birthday) Yrs	If Under Months		If Under 24 Hours		Date of Birt)2/22/	1936	Foreign	hplace (State or n S.C.
b		Usual Residence			I40- 0it-	Taura and another								4011-11-07-11-7
Tow an		10a. State	10b. County Cecil			Town or Locat		ty						10d. Inside City Limits 1 X Yes 2 No
aryland	Director	10e. Street and Nu	ımber			•	10f. Zip C	Code			10	g. Citizen of WI	nat Coun	try?
h the M 23a or 2			wn Point	Road				21915				US —	A	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marr		12. Was Decede Armed Force 1 Yes			es Decedent es, specify	Cuban, M	lexican, Pu		/ Yes or No- an, etc.)	White	e, etc.	can Indian, Black,
urs afte tural",	ya k	3 Widowed 15. Decedent's E	ducation (Specify or	If Yes, Give Year or Dates: nly highest grade o	completed)	16a. Deceder				of work	done	Specify: 16b. Kind of Bu		
336 thin 72 houne. Than "natedical Expedical E	Completed	Elementary/Sec		College (1-4		during m	ost of worki maker					own h		,
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MD 21 12 should th and Me 127 is ma umatic ev	욘		ame/Relationship (T E. Albers	ype, Print) (husbar	ıd)	19b. Mailing	g Address 7 Tow l	(Street a	nd Number int Re	or Rural oad	Route Num Chesa	per, City or Tow peake (n, State,	Zip Code)
ore, I		20a. Method of Dis	sposition Cremation 3	Removal from	State	Place of Dispos crematory or other	her place)			Da		20c. Location -	City or	Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5	Other Specify:		Mc	Crery &		_					-	
Bal permii Depar Impo injury	ł	21. Signature of Fi	uneral Service Licen	allel	65		_	-				lomes & DE 198		natory, Inc
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Examiner		Immediate Cause or condition resulti	1 1 11 1	Head and Ned									_	Death
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Box 6876 e death certificate the attending phy ed for use as the	Physician/M	past 12 month			at time of de	oth	her (Specifi	y)				E.		
1 of Vital Records, P.O. B ling Physician: The law requires that the de After this certificate has been signed by the funeral director, page 2 should be detached 1	by Ph	Part II. Other sign	ificant conditions	contributing to de		esulting in the u	ınderlying c	ause give	n in Part I.	T	_		_	ne cause of death?
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corce law re e has be	Completed			·····						- [autops perforr	y p ned? d	rior to co eath?	mpletion of cause of
I Re		25. Was case refer	red to medical				26	.Place of	Death (Che	ck only	1 ✓ Yes 2 one)	No 1	✓ Yes	2 No
Vita hysicia this ce	To Be	examiner?	2 No	ospital: 1 Inpa	itient 2	ER/Outpatient	3 DO/	A Oth	ner ₄ Nu	rsing Ho	me 5 F	Residence 6	Other:	Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	<u>=</u>	27. Manner of Dea 1 Natural	th 5 Pending	28a. Date of In FOUND:	njury y,Year)	28b. Time of In FOUND:	·	c. Injury a	it Work? 2 ✔ No		Describe hi ject fell	ow injury occurre	ed	
ivisior or Attenc after death Director:	licat	2 Accident 3 Suicide	Investigation 6 Could not l	28e Place of		0830 hrs ome, farm, stree							r or Rur	al Route Number, City
Div Hospital o 24 hours af Funcral D	Certification:	4 Homicide	determined		ingle Fam	nily Home				1647	or Town, St 7 Townpoir	ate) it Road, Ches	apeake	, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires hat the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	ल	29a. Certifier (Check only one) 2	CertifyIng Physici Medical Examiner		xamination a	-								
F 3 F 8	\$	29b. Signature and	title of certifier	and marrier state	<u>u</u>		29c. l	icense ni	umber			29d. Date signe	d (Mon	th, Day, Year)
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10		Name and add Ling Li, MD	ress of person who of Assistant M	ompleted cause o edical Examin			e Street.	Baltim	ore, MD	21223				
Sta		31. Date filed (Mon	th, Day, Year)	32. Regist	rar's Signatu									-·-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month October 20, 2012 3:50M Norma Alexander Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) April 29, 1927 Days 1 🗆 M 2 🔀 F 216-22-6026 Director 85 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Allegany Lonaconing 1 A Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 57 Jackson Street 21539 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 ₩Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse **Nursing Home** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Shearer Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Craig Alexander - Son 14831 Back Street, Midland, Maryland, 21532 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date October 23 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Frostburg Memorial Park Frostburg, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ somme disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown 9 Hinknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law has page performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, å 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending neral Director: Affilled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours at To the Funeral D completed filled i Medical Exitifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DULLA

Registra DHMH 17 Rev 7/2009

State

P.O. Box 68760

Division of Vital

randers

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pro Hi MORE Medical Lewiek HIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) 230-94-6508 Director 1 M 2 D F Virginia Feb 20 1957 or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f sho any Injury or other treumatic event, the Modical Examiner must be notified at Director 1 Yes 2 No baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Windsor 21207 USA 6615 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1977-1981 Black, White, etc. Completed by 1 ■ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Virginia Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allen - Mother 3278 Indian Oak Rd. Crewe, VA 23930 Irainia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State lewis Family Cemetery 10-21-2012 Crewe, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W Hawles Michae W.E. Hawkes & Son F.H. 604 East St. Blackstone, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 51 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and ettending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Day 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has i autopsy Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse/Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) MINASSOMD ACGUELINE

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year

NOV O

2 2012

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LARRY HOWARD ASHLEY Ottober 16, 2012 3:20P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4707 Odell Road Beltsville Prince George's Social Security Number 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 492-38-2076 Months Days 1 X M 2 - F Jury 29, 4937 Kansas **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4707 Odell Road 20705 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1955–1958 Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Fire Restoration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bill Jack Ashley Ruth Eugenia Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Carol Ashley -wife 4707 Odell Road Beltsville, Maryland 20705 20a. Method of Disposition

14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wisconsin Memorial Park 20c. Location - City or Town, State Date 10/23/2012 Brookfield, Wisconsin 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Bonald VoreBorgwardt Funeral Home, PA Donald 15on 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 5 years Physician/ Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnar 5 Other (specify) . Ectopic pregnancy Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 XNo ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury s after death.
I Director: Af 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined

completed filled in by

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Box 68760

P.0.

Records,

Division of Vital

Michael Berard, M.D. 7305 Baltimore Avenue, #107 College Park, Maryland 20740 31. Date filed (Month, Day, Year) NOV 0 2 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

October 17, 2012

29c. License number D26287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Anna Belle Birch 10 4 2012 1:40A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Dorchester Mallard Bay Care Center 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Month: Director 213-22-7766 1 🗆 M 2 🕱 F 83 MD Usual Residence of Decedent 5-23-1929 10a. State 10c, City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 273 or 12 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 277 is marked other than "natural", or items 23a or 28a-f sho in privary or other traumatic event, the Medical Examiner musts be notified at Director 1 🔀 Yes 2 🗌 No Cambridge Dorchester MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 202 Willis Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Specify: White 1 ☐ Yes 2 ₩ No Specify: Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working ır than " ⟨, the № life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's Aide 12 <u> Healthcare</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ebben McGlaughlin Iva Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Harper/daughter Church Creek Rd, Cambridge, MD 21613 2121 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/22/2012 Cambridge, MD Dorchester Park Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High St Newcomb&Collins FHCambridge. 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Merkel Cell Carcinoma years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dear Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed?/ Yes 2 No 25. Was case referred to medica completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 and title of certifie 29c. License number 29b. Signature 29d, Date signed (Month, Day, Year) HO059973 10/16/12

State Registrar 31. Date filed (Month, Day, Year)

30. Name Ind/address of person who completed cause of death (Item 23a) (Type, Print)
Particia Johnson 100 Bramble St Cambridge, MD

12-07800 Carolyn P Boyd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia		Decedent's Name (First, Middle)	e,Last)							2. Date of De			3. Time of Death
Medical Exami		Carolyn P. Boyd 4b. City, Town, or Location of Death 4c. County of Death											
						4t	. City, Town,	or Loca	ation of De			of Death	
		PGCH					Cheverly				Prince C	eorge's	3
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birtho	day)	If Under 1 Y	ear If	Under 24	Irs. 8. Date of B	irth(MM/DD/YYY)	9. Birth	olace (State or
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any	H	Usual Residence of Decedent 10a. State 10b. County		Inc. City	y, Town or	Locatio	n						0d. Inside City Limits
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215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rleed other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status		cedent Ever in l	J.S.					Specify Yes or N	o- 14. Race	- America	ın Indian, Black,
leath	Š	1 Never Married 2 M	arried Armed F	orces?		If Yes	s, specify Cul	an, Mex	xican, Pue	rto Rican, etc.)	White	e, etc.	
		3 Widowed 4 X Div	orced If Yes, Give Ye			1 \	res 2 X	No spe	ecify:		Specify:	В1	ack
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d wit	팃	17. Father's Name (First, Middle,	Last)					18.Mc	other's Na	me (First, Middle,	Maiden Surname		
at Hy	Be	Robert T	homas Boy	d Sr.						eora F.		,	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	10 E	19a. Informant's Name/Relations			19b.	Mailing /	Address (St	eet and			mber, City or Tow	n State 7	'in Code)
MD d 2 shoulth and in 27 is aumatic	-	Josephine A. K					•				Hopewell		' '
and 2	- }	20a. Method of Disposition	ay biizza				on (Name of			Date	20c. Location -		
of H		1 Burial 2 Cremation	3 Removal f		cremator					ct. 20,		J., J.	, 2
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Donation 5 Other Sp		1	Harmo	ny (Cemete:	ry		2012	Landov	er, N	Maryland
Balti permit. Departm Imports injury c	- 1	21. Signature of Funeral Service	Licens 25)		22. Na	me and Addr	ess of Fa	acility	Stewart	Funeral		
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Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the deat	h. Do not e								Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease	a. Pulmonary	thromboem	bolism								Death
Examiner		or condition resulting in death)		consequence									
- نمي		Sequentially list conditions,	_{b.} Deep vein	thrombosis	of lowe	r extre	mities						
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ed nsit	E	events resulting in death) Last	. Due to (or as a	consequence	or):								
kecut rand		Lindenber	a										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED	AMENDED										
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that the death certificate by the attending detached for use as 1	듄	Part II. Other significant conditi	ons contributing t	o death but not	resulting i	n the un	deriving caus	e aiven i	in Part I.	23e. Did	tobacco use contri	bute to the	e cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the		25. Was case referred to medical	15				26.Pla	ice of De	eath (Ched	ck only one)		<u> </u>	- []
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	g	(Check only one) 2 Medical Example 1	nysician: To the be										
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	Σ	29b. Signature and title of certifie	r 				29c. Lice			OCME	29d. Date sign	ed (Month	, Day, Year)
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45.41	ŀ	30. Name and address of person	who completed cau	se of death (Iter	n 23a)	0)							
J:#1		Theodore M. King, Jr.,				er 90	00 W. Bal	imore	Street,	Baltimore, M	D 21223		
St	ate	31. Date filed (Month, Day, Year)	14. R	egistrar's Signa	ure	anka	1				-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				and Men	tal Hygie	ene 2 n	12	35160
			Registrar	Cer	tificate of D	eath		Reg	g. No.) bun	1 (2.11
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					Month tober	10 20	Year	3. Time of Death 5:50 P M
**	Medic		James William Belton 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of		Lobel	4c. County		3:30 F
	Examin	er	8623 Seasons Way		, ,	ham	Douti				eorge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day, Y	(ear)	9. Birth Cour	place (State or Foreign
	Director		577-32-9387 1⊠м2□F 84	Yrs.	Months	riouis		y 15,			h Carolina
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation		110	., .,			10d. Inside City Limits
	tarylai 3a-f s tified	ecto	Maryland Prince George's			Lanh	am				1 🔀 Yes 2 🗌 No
	the N or 28		10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	is 23a	Funeral Director	8623 Seasons Way		2	20706			Uni	ted S	States
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 🍱 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🖾 No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican,	jin? (Specify ` , Puerto Rica	es or No- n, etc.)	Blac	e - Ameri ck, White, Blac	
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ivisio	or Atter after dea Director I in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f.	Location (Stre City or Town,		er or Rura	al Route Number,
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	Го the within Го the сощрЫ	Σ							d. Date signe		
			29b. Signature and title of certifier Focelyne Kouarchau	/ " "	29c. License 263	748			10/	2/1	2
	45m		30. Name and address of person who completed cause of death (Item 23:					1 4 4 -	- M - · ·		d 21218
			Jocelyne Kouatchou, MD 201 East 31. Date filed (Month, Day, Year)		versity	rarkwa 	ау ва	ltimor	e, Mar	yıan	21210
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DHMH 17 Rev 06-2011

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	Physicia		DANIEL	,	BOHN	SR.				OCT.	10	^{ay} 20	ear 12	3. Time of Death 2:49 AM
Ž,	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, To	own, or L	ocation of Dea		4	c. County of		
			ATLANTIC GENERA					ERLIN				WORCE		
	Funeral Director		5. Social Security Number 6. S 214-22-1974	ex 7. Age		st birthday)	If Under 1 Months		If Under 24 Hr. Hours Min	. (Month, D	ay, Year)		Count	
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0000	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give	No		☐ Yes 2			,		Specify:		HITE
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ary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (S	Street an	d Number or R	ural Route Numb	er, City c	or Town, State	e, Zip C	ode)
ນ໌ ຮັ	and 2 s lealth em 27 her tra		PATRICIA A. HEAL	E/DAUGHTER	_				RCH DRI	VE, PARA	_			
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Dalumor	permit. Page Department of Important: If any injury of once.	- 6	4 Donation 5 Other (Special Signature of Funeral Service Licenses)		CRE	MATORY	OF DE			/15/12] Di	ELMAR,	DEI	LAWARE
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			23a. Part 1. Enter the disease, or conshock, or heart failure. List only of	plications that caused ne cause on each line	the death	n. Do not ente	r the mode o	of dying,	such as cardia	c or respiratory a	irrest,			Approximate Interval Between
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	he Ho in 24 h he Fur pletely	Medical	(Check 2 L Medical Exam	iner: On the basis of ex se Practitioner: To the	amination	and/or invest	igation, in my	opinion,	death occurred	d at the time, date	and plac	e, and due to	the cau	se(s) and manner stated.
_	Voith Com		29b. Signature and title of certifier	0				icense n			29d. D	ate signed (N	Aonth, D	ay, Year)
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	670		30. Name and address of person with	eral Horn	u to	1, 97	rint)	Hea	lthrough	y Priz	1e;	Bez-	lui	-21811
	Stat Registra		31. Date filed (Month, Day, Year) OCT 16 2012	32. Regisfra	r's agnat	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Alma Wilburn Bowen October 16 2012 6:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) 213-22-0365 Director 1 □ M 2 🕅 F 98 Usual Residence of Decedent 10/07/1914 <u>Maryland</u> 28a-f show 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 1 Yes 2 X No MD Calvert Huntingtown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral ral", or items 23a Examiner must b 2995 Plum Point Road 20639 USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. "natural". 3 X Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Edwin Wilburn Mary Evelyn Cranford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page E. Bowen, Son <u>3695 Plum Point Rd.</u> Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) Emmanuel Cemetery 10/23/2012 Huntingtown, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licensee M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as the burial-transi requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) signed by the atte Id be detached for in the past 12 months Month Year Pregnant at time of death Day 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? To the Hospitallor Attending Physician: The law i within 24 hours ther death.

To the Funeral Director After this certificate has b 24a. Was an autopsy performed 1 🗌 Yes 1 ☐ Yes 2 ☐ Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natura 5 Pending 1 Tes 2 Accident Investigation in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d, Date signed (Month, Day, Year) 0 5KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Manoj Mathur, M.D.,

7 2012

31. Date filed (Month, Day, Year)

32. Registrar's Signature

110 Hospital Rd., Ste. 305, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth Boarman October 13, 2012 Arris 7:10 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3616 Littledale Road # 219 Montgomery Kensington If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) 6. Sex **Funeral** Days Months Hours (Month, Day, Year) 02/01/1931 Maryland 1 □ M 2 💢 81 218-24-0282 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ь 23a Funeral 20895 3616 Littledale Road #219 U.S. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. o, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced white "natural" Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Snydeman Sylvester Harvey Sara Alice Keck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 Woodmont Avenue # 1210, Bethesda, MD Marilynn D. Bersoff, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/17/2012 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer of pancreas Physician weeks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 Month Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 $\raisebox{-4pt}{$\stackrel{\frown}{\bf M}$}$ Residence 6 \square Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

KW

State Registrar

Barry N. Rosenbaum, M.D., 3720 Farragut Ave., Kensington, MD 31. Date filed (Month, Day, Year)

3

29b. Signature and title of certif

32. Registrar's Signature

Certifying Nurse Praction

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

r: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe D09834

29d. Date signed (Month, Day, Year)

October 16, 2012

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		-	For State	State o	T Maryiai		artmen <i>tificate</i>			anu iv	lental Hyg		20	12	25161
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	Physicia Medic	al	John F. Bilsky, Sr. 4a. Facility Name (if not institution, giv		had.		I., a., .			15	Month October	10°			01:00 A M
	Examin	er	Southern Maryland F		oer)			nton	Location of	of Death			. County o P rince		res
-	Funeral				7. Age (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Birth	h		9. Birthp	ace (State or Foreign
	Director		175-26-0821	1 (XM 2 □ F	00	Yrs.	Months	Days	Hours	Min.	(Month, Day		222	Count	ry)
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36	", or	2	1 Never Married 2 XX Married	Armed For 1 △ Yes If Yes, Giv	2 No 19	~	1 ☐ Yes 2				nican, etc.)		Black Specify:	, White, e Whi	
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2	filed al Hy d oth		17. Father's Name (First, Middle, Last)								e (First, Middle, I	Maiden	Surname)		
ya	Ment Ment arke	မ	Paul Bilski			 			Anna	a Mazi	arz				
Maryland 21215-0036	shour rand		19a. Informant's Name/Relationship (•	•			Route Number	City or	Town, Sta	ate, Zip C	ode)
e,	and 2 Healtl em 2 ther 1		Jean M. Bilsky (Wife 20a. Method of Disposition	2)	2015	9402 Place of Dispo			. Clin	<u> </u>	MD 20735	00-1		0:h T.	. 01-1-
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0	be exessician solution			■ d										_ [
6876	eath certificate k ettending phys d for use as the	Aedi		_ u								T			
8	endin r use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic p	negnanc	v				23d. Date	of delive	ry
Box	death he ett ied fo	sicl	in the past 12 months? 1 Yes 2 No 9 Unknown		nant at time of		Other (sp		,			ŀ	Mon	th	Day Y ear
P.O.	Attending Physicien: The law requires that the death certificate er death. ector: Affer this certificate has been signed by the ettending physby the funeral director, pege 2 should be detached for use as the	Completed by Physiclan/Med	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the (ınderlyina c	ause giv	en in Part	1	23e Did to	hacco	use contrib	oute to the	e cause of death?
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Records,	requi	ete									24a. Was a				sy findings available
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E E	iffication, per	မ္တ	25. Was case referred to medical				-	26 Pla	ace of Dea	th (Check		2 N	o 1	☐ Yes	2 No
of Vital	ysici is cer direc	10 B	examiner?	Hospital:	Inpatient 2 🗆	ER/Outpatie	nt 3 🗆 DC	Othe	Mr.		me 5 🗆 Resid	ence 6	5 ☐ Other	(Specify)	
ō	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date	of injury h, Day, Year)	28b. Time of injury	28	Bc. Injury work	at		28d. Describe h				
ion	tendin leath. or: Al	ifice	2 Accident Investigation 3 Suicide 6 Could not	on be			М	1 🗆 '	Yes 2□	No					
Division	a # F	Medical Certificate:	4 Homicide determined	28e. Place	of Injury - At he ng, etc. <i>(Specif</i>)		eet, factory,	, office			28f. Location (S City or Tow			or Rural	Route Number,
	To the Hospitai within 24 hours a To the Funeral I completely filled	cal	29a. Certifier 1 Certifying Ph	vsician: To the b	est of my know	ledge death	occurred at	the time	date and	I place ar	nd due to the ca	use(s) a	nd manne	r as state	d
	e Hos 24 h e Fun iletely	Medi	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the bas	is of examinatio	n and/or inves	tigation, in n	ny opinio	n, death od	ccurred at	the time, date ar	nd place	e, and due	to the cau	se(s) and manner stated.
	To th Within Comp	-	29b. Signature and title of certifier		(1)	,		License		p.			te signed		
	(KASHEINAM	4551			ト	10	45	32	5 (DOTO	BER	. 11	2012
	15/20		30. Name and address of person who	completed caus	/ / h	n 23a) (Type, f	Print))		_		4.5	047
	V		KASHEGD A	13AS			SURR	A77.	3 K	OTO	. CUI	V70/	VM	<u>ル</u>	20/35,
	Stat Registra		OCT 1 6	2012 2	egistrar's Signa	A. A	ares								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) A M Octobo 2012 trank Dernard 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Maugansville Washington 3937 Distart If Under 1 Year If Under 24 Hrs. g. Birth place (State or Foreign 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Country) 235-24-997 1 XM 2 □ F 87 Jan. 25 West Virginia 10d. Inside City Limits 10c. City, Town or Location 1 🗆 Yes 2 XNo Maryland Washington Maugansville 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? U.S.A. 2176 13937 Distant . Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1943 -1946 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government ditor 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First Middle, Last) Joseph Bargiel Nellie Dude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13937 Maugansvil le MD 21767 Frances Baralel Distant 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery 20a. Method of Disposition, 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date Hagerstown, MD 10-19-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pouglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 21. Signature of Funeral Service Licensee . 10 -

Physician/ Medical Examiner

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once.

Baltimore, Maryland 21215-0036

notified at

Director

Funeral

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Completed

Be

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signed by the attending physician and Idea be detached for use as the burial-transit filled in by the funeral

Stephen 31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Hatleberg

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

after death.

Director: After this certificate h

- 1	Parties garra	unstulo	1 1144 618 18 14 17 1 1 1	
		ations that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
	resulting in death)	Due to (r s a consequence of):		
	Sequentially list conditions, b. if any, teading to immediate cause. Enter Underlying	Due to for all a consulpuence of):		YRARS
מוכמו דעמו	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
y Sician in the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. If yes, outcome of pregnancy 1	23d. Date of de Month	elivery Day Year
20.00	Part II. Other significant conditions conti	ibuting to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
naidino.	PHENMONIA Charic Ren	Al disease	autopsy prior to	utopsy findings available completion of cause of es 2 \(\sumsymbol{\subset} \) No
D	25. Was case referred to medical	26. Place of Death (Check	k only one)	
2	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Spe	cify)
care.	27. Manner of Death 12 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
Medica	(Chook 2 Medical Examine	an: To the best of my knowledge, death occurred at the time, date and place, ar r: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To #re best of my knowledge, death occurred at the time, date and pla	t the time, date and place, and due to the	cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Icto De

Ave Suite 203 Hagerstown, ND 21742

2012

DHMH 17 Rev 06-2011

State Registrar

IN-10+

13424 Pennsylvania

Rafistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 012 Physician/ octobe ELYN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Howard Columbia Howard County General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months (Month, Day, Year) 06/09/1927 Days **Funeral** 1 🗆 M 2 🗓 F Pennsylvania 85 213-22-3509 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State notified at Director 1 Yes 2 No Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number P USA 21045 traumatic event, the Medical Examiner must be 23a Funeral 9525 Pepple Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 X No 1 Never Married 2 K Married ò 1 ☐ Yes 2 X No Specify: Specify. White Baltimore, Maryland 21215-0036 3 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Home Elementary/Seconday (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Pearl Donahue ပ Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9525 Pepple Drive, Columbia, MD 21045 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) Bernard J. Borgman / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet Cem @ Rocky Gap 10/24/2012 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Flintstone, MD MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): ocardial Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ 23b. Was decedent pregnant Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 No 1 🗌 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No hours after death. neral Director: Aft 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation 2 Accident 3 Suicide 4 Homicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

in 24 hour.
io the Funeral Dr.
completed filler 122

31. Date filed (Month, Day,

3 [

29b. Signature and title of certifier

GOBERT 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

29a. Certifier

only one

55

29c. License number

D0073466

CEDAR LANE COLUMBIA MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Elmer F. Blank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Regional Medical Center Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days **Director** 214-32-3031 1 **X** M 2 □ F 82 March 21, 1930 Maryland Usual Residence of Dec or 28a-f show Oa. State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland at Director Examiner must be notified 1 XYes 2 □ No Mount Savage Maryland Allegany 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15712 Upper Bank Street 23a Funeral 21545-U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates (Dred) 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 3 Architectural Engineer Tire Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Blank Mary C. Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Helen M. Blank Wife 15712 Upper Bank Street Maryland 21545-Mount Savage 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. George's Episcopal Cemetery October 26, 2012 Mount Savage Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) subdinal Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has page 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) work? 1 🔲 Yes 1 Natural
2 Accident 5 Pending s after death. Investigation 15 М the 28f. Location (Street and Number or Rural Route Number, City or Town, State) IN + SAU + CE MA 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of In ury - At home, farm, street, factory, office filled in by determined building, etc. (Specify) 15 BANG 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I only one) 29b. Signature and title 29d, Date signed (Month, Day, Year) 29c. License number MD D72514 10. 22, 2012 8

Registrar

DHMH 17 Rev 06-2011

Kelly

31. Date filed (Month, Day,

OCT

Rd

Willowbrook

32. Registrar's Signature

Cumberland

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12500

2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	d / Department of Certificate of		ental Hygier Reg. 1		35168
			Registrar 1. Decedent's Name (First, Middle, Last)		- Cortinoato c		2. Date of Death	40.	3. Time of Death
	Physici	an	7	1 B X				Day Year	1:45A M
	/Medic		4a. Fecility Name (If not institution, give s	niel Bak		n, or Location of Death		4c. County of Death	11737
	Examin	er	4a. Feditiy Name (ii not institution, give s	11	1			Allec	col
			5. Social Security Number 6. Sex	7. Age (In yrs. la		berland ar If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral			M 2□F	Yrs. Months Da		(Month, Day, Yes	ar) Cou	ntry) md.
	Director		Usual Residence of Decedent			0,	10-18-1	2	711001
	and tand		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Many	ō	md Alleg	600	umber la	10			1 ✓ Yes 2 □ No
	288-	Director	10e. Street and Number	ang	10f. Zip Coo		10g.	Citizen of What Cou	ntry?
	with a or			Α.	2	1502		110-10-1	St les
	ours after death with the Marylan rai', or items 23a or 28a-f show Extropher must be rouffled at	Funeral	446 Balti	12. Was Decedent Ever in U.S			city Yes or No-	14. Race · Ameri	can Indian,
	ter d	Ę.	1 Never Married 2 Married	Armed Forces?	If Yes, specify 0	of Hispanic Origin? (Spe Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	etc.
36	rs af	by	3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø	No Specify:		Specify:	shite
21215-0036	72 hours after death with the Maryland "neturel", or items 23a or 28a-f show officel Exerciper must be rediffed at		15. Decedent's Educ	cation	16a. Decedent's Usual Oc	cupation		. Kind of Business/Ir	ndustry
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72	within iene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Infant			NONE.	
	filled Hyg other		17. Father's Name (First, Middle, Last)		1.1.00	18. Mother's Name	(First, Middle, Maio	len Sumame)	
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Maryland	d 2 should h and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Ty)	ag Print)	19h Mailing Address (St				
<u>S</u>	12 ha		Somentha Jo B	aker Mother		altimore	-0		berland Md
Ġ	s 1 and f Health item 27 other tr		20a, Method of Disposition	20b. Pla	ace of Disposition (Name o	f D		Location - City or T	
סר	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	metery, crematory or other		/2012 0	umberland	MD
altimore	nit. Pag artment ortant: I injury o		4 Donation 5 Other (Specify)		berland Crem	actory 10/19	me Family		
Bal	Departm Departm Imports Iny inju		21. Signature of Funeral Service License	90		tur Street,	_		1502
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g.			23a. Part1. Boter the disease, or compli shock, or heart failure. List only or	cations that caused the death re cause on each line.	. Do not enter the mode of	dying, such as cardiac o	r respiratory arrest,	-	Approximate Interval Between Onset and Death
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	/Medical		resulting in death)	Due to (or as a consequ	ence of):	- 14	•		
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Вох	eath certific attending p	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar				23d. Date of deliv	very
m	atte atte	cla	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de				Month	Day Year
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0_	that ned by deta		Part II. Other significant conditions con	tributing to death but not resu	Ilting in the underlying cause	given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	sign d be	d by	Smentan	eon Rus	Ture of 1	nembrance	1 ☐ Yes	2500 3 Pro	babiy 4 Unknown
Ö	v requir been si should	Completed			-		24a. Was an	24h Were aut	opsy findings available
ec	elaw hasl	du					autopsy performed	prior to c	ompletion of cause of
=		S					1□ Yes 2□		212 No
Vital	Physician: The rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	L. William		26. Place of Death	(Check only one)		
of \	hysi his o	2	1 LI YOS ZIX NO	lospital: 1 Inpatient 2 1	ER/Outpatient 3☐ DOA			6 ☐Other (Spec	ity)
	ding Ph h. After th funeral	ino	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Work?	28d. Describe how i	njury occurred	
.0	uttendin death. ctor: Af y the fur	atle	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	after de Directo	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, of	fice	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
O	the Hospitel or Attending hin 24 hours after death. the Funerel Director: Atte npletely filled in by the fune	Certification		4	,	1			
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	To the Hospitel within 24 hours a To the Funerel I completely filled	2	29b. Signature and title of certifier	-		cense number		Date signed (Month	,
			Allah Lucke	bul D.O.	HC	063734	,	10/18/	2012
			30. Name and address of person who co	ompleted cause of death (Item					
7	268		30. Name and address of person Ario co Dale Wolford, D	.u., 12502 Wil	Llowbrook Ros	aa, Cumberla	ına, MD 2	21502	
	Sta	ate	31. Date filed (Month, Day, Yaar)	32. Registrar's Signal					
	Regist		31. Date filed (Month Day, Year) OCT 2 2 2012	· Resider A	Marked				

DHMH 17 Rev 1/2001

VOID

CERTIFICATE

2012-35169

SEE

CERTIFICATE

2012 - 34897

Angela Carter

Completed 1-4-2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012^a 5:35 Montgomery Daniel Cornwell Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Burnett-Calvert Hospice House Prince Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 578-30-4317 Days (Month, Day, Year) **XX** M 2 □ F Director 84 Washington, DC Feb. 23, 1928 Usual Residence of Decedent 28a-f show 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 1 🗌 Yes 2 🎇 No Maryland Prince Georges Waldorf 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 16600 Bealle Hill Rd. 20601 U.S.A Page 1 and 2 should be filed within 72 hours after death ment of health and Mental Hygiene. and If item 27 is marked other than "natural", or items ant If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White 3 Nidowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Montgomery Cornwell Emma Wallingsford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lamont Cornwell (Son) 26320 Coombs Oaks Way Mechanicsville, MD 20659 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Oct. 15, 2012 Clinton, MD Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licens MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par71. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CEREBROVASCULAR Onset and Death DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a conse wence of Exami Cause (Disease or injury that initiated events resulting in death) Last ending physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CORONARY ARTERY DISCASE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PARKINSONS MISEASE 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) HO5P/CE 27. Manner of Death 1 Natural 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

SURESU

D53782

OCTOBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD SUITE 101, FORT WASH 11701 LIVINGSTON VERCHESE

Registrar

Registrar's Signat

PHY STCI AN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Norma Grace Cauley October 10:30 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center Cumberland Allegany 5. Social Security Number If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours 235-32-6854 88 **Director** 1 M 2 XF 11/18/1923 Yrs. Maryland Usual Residence of Deced 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director s 23a or zo... must be notified a MD Allegany Cumberland 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 220 Somerville Avenue, Apt 216 Funeral 21502 USA **Examiner must** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. è 9 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ Clint Saville Eva Malady permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol J. Taccino / Daughter 355 Bedford Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 10/22/2012 Cumberland, MD re of Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Corona Medical Due to (or as a conse wence of) * Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami executed and -trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 autopsy page 1 Yes 2 🗌 No certificate Yes 2 L hin 24 hours after death.

the Funeral Director: After this certifical projectely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospita Other 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within To the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of 29c. License number 5 2012 20 100 33280

Registrar

State

625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

2012

2 201

31. Date filed (Month, OCT 2

OCT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 9 Audrey B. Cox Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Braddock Hgts. Vindobona Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. 117387, Year) 214-34-9872 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Middletown Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 S. Jefferson St. 21769 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 X Never Married 2 Married ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗵 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 aide domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filec treent of Health and Mental H rtant: If item 27 is marked of ijury or other traumatic ever ည William Johnson Clara Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Robert Palm (Cousin) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 🙀 Cremation 3 Removal from State Smithsburg Crematory 10/12/2012 Donation 5 Other (Specify) Signature of Furieral Sen vice MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ME Physician/ mucen TASTATI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No as been signed by the 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy page perform 2 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 2 Accident 3 Suicide injury work' 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10118 Silver Twine, Columbia, MD 21046 20c. Location - City or Town, State Smithsburg, MD ²²Donald B: Thompson Funeral Home Approximate Interval Between Onset and Death 23d. Date of delivery Year Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 4 Nursing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Toll House Ave theornice Mo 21701 814 32. Registrar's Signature **ORIGINAL**

3. Time of Death

4 Ρ.

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 ☐ No

201^{Year}

Frederick

Black, White, etc.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

IBTE 31. Date filed (Month, Day, Year)

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KAZMI

MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Depedent's Name (Firs) Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil 104 Jackson Hall School Rd. E1kton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 552-44-7296 1 □ M 2 F Director 78 NY 8/8/1934 lem 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Evernmen must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours efter death with the Maryland Director E1kton 1 🗆 Yes 2 No Cecil MD 10e Street and Number 10f Zip Code 10g. Citizen of What Country? USA Funeral 21921 104 Jackson Hall School Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) end Mentel Hygiene. Is marked other then College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen R. Roper å Vernon M. Marquis permit, Pege 1 and 2 should I Department of Heelth end Me Importent: If Item 27 Is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Jackson Hall School Rd. Elkton, MD 21921 Edward L. Cairns/ Husband altimore, 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Injury or 1 XBurial 2X Cremation 3 Removal from State Newark, DE 4 Donation 5 Other (Specify) Head of Christiana 10/13/12 Sign of re of Funeral Service L Name and Address of Facility
I. Foard & Jones, Inc. eny Main St. Newark, DE 19711 Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final ARKinson 20 R Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an perform Yes 2 No 25. Was case referred to medica a 26. Place of Death (Check only one) examiner Other: 2 No 1 Tes 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) |@ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: C Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		•	For State Registrar					tificate o			Reg. No.		
	Physicia	ın/	1. Decedent's Name		,		-		· · ·	2. Date of De	ath Day	Year	3. Time of Death
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	Funeral		Social Security N	umber 6		. Age (In yrs. I		If Under 1 Ye			th ay, Year)	9. Birth	place (State or Foreign
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71	fand f shov	tor	10a. State MD	10b. County	ester	10c. Cit	y, Town or Lo		Cambridae				10d. Inside City Limits
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na			6 -			eet and Number or Ri				
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Ž	Physicia this cert ral direct	욘	1 Yes 2 27. Manner of Deatl		Hospital: In 28a. Date of	patient 2	ER/Outpatier	it 3 🗆 DOA	Other: 4 Nursing I njury at	Home 5 Resi			<u>(y</u>
Division of Vital Records,	nding ath. :: After e funer	Certificate:	1 Natural 2 Accident	5 Pending	(Month	, Day, Year)	injury	1	work?	28d. Describe	now injury oc	curred	
/isic	r Atter ter deg rector	ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place o	f Injury - At ho	ome, farm, str	eet, factory, offi	ice	28f. Location (um <i>ber or R</i> ura	Al Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland	d / Department of H		∕lental Hygi	ene 2012	35176
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of E	<i>Death</i>	2. Date of Death	g. No.	3. Time of Death
	Physicia		Howard Delanes	>		October	13 2012	5:39 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		Location of Death		4c. County of Deat	
sul!			Doctor's Community Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las		Lanham If Under 24 Hrs.	8. Date of Birth		George's hplace (State or Foreign
	Funeral Director		579-64-0596 18M2DE	Months Days Yrs.	Hours Min.	(Month, Day,		intry)
			Usual Residence of Decedent 65			March 2	1947	DC 10d. Inside City Limits
	iryland I-f sho ied at	Director		Town or Location	T 1			1 X Yes 2 No
	he Ma or 28a or potif	Dire	Maryland Prince George's 10e. Street and Number	10f. Zip Code	Lanh		Dg. Citizen of What Co	
	with t	Funeral	8801 Jenna Court	2	0706		United	States
	death items ner m		11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	after al", or 'xamii	d by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Never 1 Nev	1 Yes 2 🗚 No	Specify:			lack
21215-0036	hours natura iical E	Completed	15. Decedent's Education	16a. Decedent's Usual Occup	ation	dina .	16b. Kind of Business/	Industry
2	nin 72 ne. han ", e Mec	dwo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done of life. DO NOT use retired)		arig		
72	ed with Hygier ither t	0	17. Father's Name (First, Middle, Last)	Comput		ne (First, Middle, M	Xerox	ζ
auc	be file ental I rked o ic eve	일	Howard L. Delaney, Sr.			erdie Bla		
lary	should and M is ma aumat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a			-	Code)
Baltimore, Maryland	and 2 stealth		Ethel M. Delaney - Wife	8801 Jenna Co				· · · · · · · · · · · · · · · · · · ·
JOE	nt of h		1 Burial 2 X Cremation 3 Removal from State ce	ace of Disposition (Name of emetery, crematory or other place		• 20, 012	20c. Location - City or	Maryland
뵱	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Lee's Cremator			uneral Hom	
m	Depar Impo any ir once		John 1- Stewart M0056				hington, D	C 20019
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			or respiratory arres	st,	Approximate Interval Between Onset and Death
	Medical	0.9	Immediate Cause (Final disease or condition resulting in death)	vascular Di	sease			Many yrs.
1	Examiner		Uncont	ence of: rolled Dia	betes			Manyyes
	_ #	Examiner	if any, leading to immediate Due to (or as a consequence)	ence of):				<u> </u>
	ecuted and I-trans	xarr	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the	Obesity ence of):				Monyyrs
0	te be executed nysician and he burial-transit		d	· 				
P.O. Box 68760	ificate ng phy as the	Physician/Medical	IF FEMALE:					
9 ×	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live Birth 2 Fetal	death 3 🔲 Ectopic pregnand	;y		23d. Date of de Month	livery Day Year
B	re dea	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	eath 5 🗆 Other (specify)				
P.0	requires that the death certificate been signed by the attending physhould be detached for use as the	by Pł	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause give	ven in Part I.		acco use contribute to	
ds,	quires en sig ould b	ted I	Hypertension, Hyperli	pidemia,		1 🗆 Ye	s 2 No 3 P	robably 4 Unknown
200	law re nas be e 2 sh	Completed	Anasurca			24a. Was ar autops perforn	y prior to	topsy findings available completion of cause of
æ	rsician: The law r s certificate has b director, page 2 s	Co	25. Was case referred to medical	ac Di		1 🗆 Yes 2		s 2 No
/ita	/siciar s certil	To Be	examiner?	ER/Outpatient 3 DOA Oth	ace of Death (Checer: 4 Nursing F		nce 6 Other (Spec	cify)
of	l or Attending Phys aft r death. Di ector After this d in by the funeral d			28b. Time of 28c. Injury work	y at	28d. Describe ho		
ion	teridii death. tor Al	Certificate:	2 Accident Investigation		Yes 2 No	005	reet and Number or Ru	ural Pouto Numbar
Division of Vital Records,	aff ro		4 Homicide determined building, etc. (Specify)	me, farm, street, factory, office		City or Town		nai rioute ivanisei,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aft indeath. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	edical	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check 2 Medical Examiner: On the basis of examination	edge, death occurred at the time	e, date and place,	and due to the cau	se(s) and manner as s	tated.
	the H thin 24 the F mplete	Me	only one) 3 Certifying Nurse Practitioner: To the best of m	ly knowledge, death occurred at 29c. License	the time, date and p	lace, and due to the	e cause(s) and manner a	as stated.
	2 € € 0		29b. Signature and title of certifier	D3	1001		10/15/	2012
	Sm		30. Name and address of person who completed clause of death (Item	23a) (Type, Print) 750	o Green	Tray C	n/r.Dr. 3	#430
						- C M	-770	
			Stuort Turkewitz, MD.		enbelt,	770 2	0770	
	Sta Registr				enbelt,	. 770 2	0++0	

Dionte Days				or Print in Book of Maryland	/ Depart	ment o	f Health an			gible. 20	2 3517
	Regi	or State strar			Certi	ficate o	f Death			g. No.	
Physician Medical Examine	4	ecedent's Name LONTE	(First, Middle,La	st)					2. Date of Deat Month October 12	Day Year	3. Time of Death 0218 hrs
		Facility Name (if Prince Georg	_	ve street and number)		4b. City, Town, or Cheverly	Location of Dea	th	4c. County of De Prince Geo	
Funeral Director		ocial Security No			je (In yrs. last	birthday)	If Under 1 Year Months Day			h(MM/DD/YYYY) 9.	reign
Director	<u> </u>	al Residence of		YM 2□F	23	Yr			12-12	-1988	Country) DC
w any	10a.	. State 1	0b. County		10c. City, To		tion				10d. Inside City Limits
Maryland 28a-f show d at once,	5 M	D . Street and Num	PG		LANDO	/ER	10f. Zip Code	· · · · · ·	[10	Og. Citizen of What O	1 X Yes 2 No
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leath with	11. N	Marital Status	d 2 Marrie	12. Was Deceden				spanic Origin? (Specify Yes or No- to Rican, etc.)		nerican Indian, Black,
fter dea	3	Widowed		1 Yes 2	X No	1	Yes 2 X No	specify:		Specify: B]	LACK
hours aft natural" Examine				nly highest grade cor		6a. Decede	nt's Usual Occupa	tion (Give kind of	f work done	16b. Kind of Busine	ss/Industry
5-0036 ed within 72 hour tygiene. other than "natt the Medical Exa		lementary/Secon	ndary (0-12)	College (1-4 or		robe v	IANAGER		,	PRIVATE	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica			First, Middle, Las)	р.	IOKE I		18.Mother's Nam	ne (First, Middle, M		
2121 ould be fi d Mental s marked tic event,		ON ROBII	NSON ne/Relationship (Type, Print)		19b. Mailin	9 Address (Stree	APRIL D.		ber, City or Town, S	tate. Zip Code)
MD dd 2 shor lith and an 27 is numatic	AP		S/MOTHER			6706	ASSET DE	RIVE, LA	NDOVER,	MD 20785	
		Method of Dispox X Burial 2		Removal from St			sition (Name of ce her place)		Date	20c. Location - City	
Baltimore, pernit. Pages I a Department of He Important: If ite	21. \$	Donation 5	Other Specify	rsee	HAR	MONY N	IEMORIAL Name and Address	CEMETER s of Facility DO	Y PE FINED	LANDOVER	ъ л
Ba perm perm Loppi Imp		KAIT	a. A	wy More		55	38 MARLE	BORO PIK	E, FORES	TVILLE, M	
Physician		failure. List only	one/cause on e				he mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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4	Seq if an	uentially list con		Due to (or as a cons	equence of):						
ted nisit	caus (Dis	se. Enter Under sease or injury th	lying Cause at initiated c	Due to (or as a cons							
executed an and al - transit		nts resulting in d	eath) Last	•	equence or).						
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Box 68760, e death certificate be the attending physici of for use as the built busician/Med	<u> </u>	Yes 2 N	o 9 🗌 Unknow		time of death	5 0	ther (Specify)				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriedical Certification: To Be Completed by Physician/Medicalical Certification: To Be Completed by Physician/Medicalical Certification:		t II. Other signifi	cant conditions	contributing to deat	h but not resu	ılting in the	underlying cause (given in Part I.			to the cause of death?
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one)	on only		r: On the basis of exa	-						
	29b.	. Signature and t	itle of certifier	/		_//	29c. Licens			29d. Date signed (October 12, 20	
4 _{5.m}	30. 1	Name and addre	ss of person who	completed cause of	death (Item 23	D (/	1 / 0.0.	I T (. b			· 1 ·
Ç,AT	F	Russell Alex	ander MD.	Assistant Medic	al Examir	er 900	W. Baltimore	Street, Balti	more, MD 212	223	
Stat Registra		Date filed (Month	CT 1 2	012 32. Registra	ar's Signature	. 5576	affect	-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 0845AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death #714 Diamice If Under 1 Year I If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 431-50-3513 1 □ M 2 🔀 F 82 05/11/1930 Arkansas and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 714 21804 USA 320 Mill Pond Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Wicomico County Dept of Elementary/Secondary (0-12) College (1-4 or 5+) 12 Social Services Medical Interviewer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Impofrant: If Item 27 is marked any injury or other traumatic events. ၉ Benjamin Wilbur Cox Bessie Mae Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 320 Mill Pond Lane 714, Salisbury, MD 21804 Thomas A. Dawson Jr/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/16/2012 Wicomico Memorial Park Salisbury, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, t 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of c 29b. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solut MD 21802 HB5 Coasto Orexel 31. Date filed (Month, Day, Year) 32. Registrar's signature State 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 State
Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dawson 3. Physician/ Dortha Lee Medical 4c. County of Death
Allegany 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Cumberland Western MD Regional Medical Center 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 234-46-6854 **Director** 1 🗆 M 2 🗶 F Maryland 07/27/1931 Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Fleatth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at Director Frostburg 1 XYes 2 No MD Allegany 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 21532 100 Braddock Street, Unit 604 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: 3 🛱 Widowed 4 🗆 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Uphole Brendlin Juanita ည Harrison Earl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Braddock St, Unit 604, Frostburg, MD Kellee Dawson / Daughter item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, cemetery, crematory or other place) 1 \nearrow Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) Cumberland, MD Sunset Memorial Park 10/25/2012 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine Due to or as a consequence of): cause. Enter Underlying Cause (Disease or injury -transit Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for 1 in the past 12 months? Month Year Pregnant at time of death Unknown 2 400 ed by the a 9 Unknown signed by tall be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown been signated by the second of Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 perform death? 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Uspatient 2 ER/Outpatient 3 DOA မ After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Funeral Director: A stely filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 5 ompleted cause of death (Item 23a) (Type, Print) 12502

State

31. Date filed

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Oct 18 [™]2012 Physician/ 11:10 pn₩ Dahlen Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Allegany Health Nursing and Rehab If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthpu Country) PA **Funeral** Days Hours Aug 14 1 □ M 2 □ F Director 202-16-5729 89 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he marified of 10a. State 10b, County Director Cumberland MD Allegany 1 🙀 Yes 2 🗆 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 730 Furnace St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: 3 X Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Westinghouse Air Arm circuit board assemblier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Martha Royer Randler Elmer S. Randler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12118 Bedford Rd. NE Cumberland MD MD 21502 Gerald Wagner son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home P.A. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State 10/19/2012 MDCresaptown Other (Specify) 4 Donation al Service Licens 22. Name and Address of Facility ral Home, PA 21. Signatui 108 Virginia Avenue: Cumberland, MD 21502 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock. Immediate Gause (Fi use (Final Physician/ END STAGE ALZHEINETC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Use to (or as a consequency of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for Year Month Day Pregnant at time of death g 🗌 Unknown should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 Ves 2 ANO 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, wano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Glenn Street, Suite 302, Cumberland, MD 21502 Robustiano J. Barrera, Jr., M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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		Registrar 1. Decedent's Nam	ne (First, Middle, La	ıst)		Oei	incate of i	- Journ	2. Date of De			3. Time	of Death
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Examin	_	4a. Facility Name (i	if not institution, giv	e street and numbe	r)		4b. City, Town, o	r Location of Death			County of De	ath	
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Funeral Director		373-40-2		1 X M 2 □ F	71	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	C	Country)	
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the M	₫	10e. Street and Nu			LEIK		10f. Zip Code			10g. Citiz	en of What C	Country?	
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d be fi Mental arked itic ev	유	Frederic	k A. Der	myer				Ruth Ma	ttis				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			lame/Relationship (•	and Number or Rura			own, State, 2	Zip Code)	
and 2 Health em 27	-	Betty De	ermyer /	Wife	20h P		Liver Roa sition (Name of	d, Elkton	n, MD 2. Date		ation - City o	or Town, State	
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quires en sig ould b	ted								1 🗆	Yes 2	No 3 □	Probably 4	Unknown
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ng Ph fter thi Ineral		27. Manner of Dea	ath 5 Pending	28a. Date of		28b. Time of injury	28c. Injur worl	ry at	28d. Describe				
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or Ai after Direct		4 Homicide	e determined		, etc. (Specify,		eet, factory, office		City or To		Number or r	nurar noute Ni	imber,
To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		1 Certifying Ph	ysician: To the bes	t of my knowl	edge, death o	occurred at the tim	ne, date and place, a ion, death occurred a	nd due to the c	ause(s) and	d manner as	stated.	manner stated
the H thin 24 the F	Me		3 Certifying Nu					the time, date and pl		the cause(s	and manner		
7		Signature and	a title of certifier				P6	5902		290. Date	0/12	/12	
		30. Name and add	dress of person who	completed cause	of death (Item	23a) (Type, F	ton M	10 2	1921	1	Sr. Go	pez	
Stat	е	31. Date filed (Mon		32. Reg	istrar's Signat		1					1	
Registra	r		UU1 12	2014	geres.	1 19	back						

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			State of Maryland / Department State		Mental Hygie	ne 2012 35182
			Registrar	tificate of Death	Reg.	No.
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Judith Leah Dudley		2. Date of Death Month	Day Year 3. Time of Death
Yes	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Oct. 12	2, 2012 10:45 P ^M 4c. County of Death
	Examin	er	5930 Winters Dr.	La Plata		Charles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9, Birthplace (State or Foreign Country)
	Director		217-68-9125 1 □ M 2 □xF 55 Yrs.		04/03/1	
	ind show at	5	10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD Charles La Plat	a		1 ☐ Yes 2 🖾 No
	a or 2 be no		10e. Street and Number	10f. Zip Code		Citizen of What Country?
	s filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral I	5930 Winters Dr.	20646		
	r deat	교	Armed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
920	s afte ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1 ☐ Yes 2 🗓 No Specify:		Specify: White
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land	ould be file of Mental I marked c matic eve	10	Abner Elwood Dudley, Sr.			eth Posey
ary	e should be file h and Mental 7 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rur	al Route Number, Cit	y or Town, State, Zip Code)
Σ	ealth an 27 in 27 iner tra			Winters Dr.,		
ore	ye 1au tof H If itel or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremation 2 Removal from State	natory or other place)		c. Location - City or Town, State
Baltimore, Maryland 21215-0036	it. Pag rtmen rtant; njury			Mem. Gds. 10/		aldorf, MD
Bal	permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service License M0 0 6 4 1	Ray	ymond Fu	neral Svc., P.A. a Plata, MD 20646
Г	4271		23a. Part 1. Enter the disease, or complications that caused the death. Do not entended, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
case !	Physicium/		Immediate Cause (Final disease or condition	Conce	1	Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):		1	
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	ted J ansit	Examine	cause. Enter Underlying Cause (Disease or injury			
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687	irtifica ling pl	/Me	IF FEMALE: 23b. Mas decedent pregnant 23c. If yes, outcome of pregnancy			
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on	ttending I death. stor: After y the funer	ficat	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
Division		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
۵	Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investorly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	at the time, date and p	lace, and due to the cause(s) and manner stated.
_	To the virthing complete the co		29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
	mai		* K Taller	1 1792 21	2	10-11
	1011		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Daf 35 Waldor	1 MD	20603
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			<u> </u>
	Registr	ar	NOV 0 2 2012 Serve B. Jan			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:20 A^M Physician/ CHARLES ELLERBE 2012 DAVID October Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring 13317 Sherwood Forest Drive g. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth If Under 1 Year Age (In yrs. last birthday) 5 Social Security Number (Month, Day, Year) ec. 5. 1922 South Carolina **Funeral** Days Dec. 89 250-22-4210 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1X Yes 2 No Silver Spring Marvland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20904 Completed by Funeral 13317 Sherwood Forest Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married African American Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours afti nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural"; 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self. Employed Pharmacist Be 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Gardner Isabella ပ Clea Ceasar traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 19a. Informant's Name/Relationship (Type, Print) 2445 Lyttonsville Rd., Apt.716, Silver Spring, MD (Daughter) Arnett Marv Ε. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a Method of Disposition Department of H Important: If ite any injury or oth Riverdale Park 1 Burial 2 X Cremation 3 Removal from State 10/23/12 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Jordan Funeral Service, Inc. CC0341 21. Signature of Funeral Service Licensee 20019 Washington, DC 4001 Benning Rd., NE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Se_uentially list conditions, if any, leading to immediate cause. Enter Underlying Examine executed 580 Ma Cause (Disease or liniury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery use 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ō Pregnant at time of death signed by the a d be detached f Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 1 🗌 Yes Yes 27 LVIng 26. Place of Death (Check only one) To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital Assisted 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Natural 2 Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

1+1 511

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver Spring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David L. Elwood Jr. Medical October ģ 2012 5:30p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Ctr Cecil Rising Sun Social Security Number 6. Sex If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Davs (Month, Day, Year) **Director** 222-10-5639
Usual Residence of Decedent 1 XM 2 □ F 89 Yrs. 4/8/1923 DE 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 21/2 No MD Cecil Rising Sun 10e, Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Completed by Funeral 165 Chandlee Rd 21911 USA and 2 should be filed within 72 hours after death Mealth and Mental Hygiene. em 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify White 3 Widowed 4 Divorced Specify: Year or Dates: 1 9 4 2 - 4 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 10 Machinist/ Millwright Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Leroy Elwood Sr. Marquerite Toner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Paul Elwood / Son Chandlee Rd. Rising Sun, MD 21911 20a. Method of Disposition Department of H Important: If ite any injury or otl once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/17/12 DelVet Memorial Cemetery Bear, DE Signature of Funeral Service Licenses R.T. Foard Funeral Home, P.A. S. Oueen St. Rising Part 1 Enter the disease, or compli-shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Interval Between Immediate Cause (Final Onset and Death Physician Alzheimen's ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 8 signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Muasthenias Records, been sig 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an Were autopsy findings available page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospita 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and title of certifier 5+ 00058 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA NEIL E LATTIN, M.D. 101 COLUMBI 31. Date filed (Month 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Month 14:19 PM rus 81 actioner" Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days Director 220-30-9651 1 X M 2 - F 87 Aug.17, 1925 Maryland Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 27 No Maryland Frederick Myersville 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code pe r , or items 23a Funeral 12331 Pleasant Walk Road must 21773 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced 4 Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Farmer Dairy Farm 6 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Early Susan Irene Pryor Cyrus Welty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12331 Pleasant Walk Road, Myersville, MD 21773 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Hazel Early / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Reproval from Grossnickle Brethren Oct.22,2012 Myersville, Maryland Donation 5 Other (Specif uneral Service 504 Main Street 22. Name and Address of Facility ature of Myersville, MD 21773 Ricketts Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_{sici} n ntracrania disease or condition musi Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine ff any, leading to immedicause. Enter Underlying Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAM NER The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1-🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO057600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallaway MD 229 (1 Jeffran Blv2) Smithours 32. Registrar's Signature MD 31. Date filed (Month, Day, Year) State CVOM

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month, D: 33 PM Daniel Anthony Foote Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 123 Doub Way Washington Hagerstown 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year, 1 X M 2 🗆 F Director 9 1993 <u>Jamaic</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Marvland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 123 Doub Way within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No and Mental Hygiene. is marked other than "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 12 0 None None æ filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be find of Health and Mentaler. If item 27 is marked y or other traumatic ev ဥ Willette Rosemarie Haughton Aldington Foote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Craig - Brother 123 Doub Way, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 10/28/2012 | Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 10 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ 05 leosarcoma Vear disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 Mo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 7 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Matural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 2012

State

Registrar

31. Date filed (Month

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90+5 TOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of 2. Date of Death Physician/ Month Rebecca Louise Farlow October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pittsville Wicomico 35285 Poplar Neck Road If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Months Hours Min. (Month, Day, Year) Director 214-32-0657 1 M 2 K F 80 Yrs 02/21/1932 Maryland Usual Residence of Decedent in than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director 1 🗆 Yes 2 🙀 No Maryland Pittsville Wicomico 10e. Street and Number 10g. Citizen of What Country? Funeral 21850 USA 35285 Poplar Neck Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any Injury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Insurance Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Alberta Wilkins Edwin R. Adkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35285 Poplar Neck Rd., Pittsville, MD 21850 19a. Informant's Name/Relationship (Type, Print) Joshua L. Farlow/Spouse Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pittsville Cemetery 10/15/2012 Pittsville, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 nature of Funeral Service Licenses 34 CRSP Lacourage 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury woreson Due to (or as a consequence of): use as the burial-transit Exam thet the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the ettending physician page 2 should be detached for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 1 N 1 ☐ Yes 2 ☐ No e Hospital or Attending Physicien: 124 hours after death. e Funerel Director: After this certifics 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 2 1 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 53825 10 15 2012 MO and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 00 16 2012 32. Registrar's Signature State

Registrar

parks

knun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Fritz Johnson October 20, 2012 Eldrin 10:10 P M 4b. City, Town, or Location of Death Cumberland 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany Golden Living Center If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 10/25/1923 Maryland 217-18-4201 88 1 X M 2 🗆 F Yrs. Usual Residence of Dece 10d. Inside City Limits 10b. County 10c. City, Town or Location Cumberland Allegany 1 X Yes 2 No 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 21502 1510 Frederick Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. ed Forces? Yes 2 No Black, White, etc 1 Y Yes 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Carman 18. Mother's Name *(First, Middle, Maiden Surname)* Bessie Josephine 17. Father's Name (First, Middle, Last) Johnson Fritz, Sr. Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 120 Mullen Street, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Louise Twigg / Sister-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 10/24/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F. A. gnature of Funeral Service 21502 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 nrome disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

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Director

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10a. State

MD

28a-f show

ms 23a or 28a-f s must be notified

ian "natural", or items Medical Examiner mu

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menone.

death with

permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

> attending physician and for use as the burial-tran ate has been signed by the a page 2 should be detached f director. the funeral hours after death. Ineral Director; A filled in by

Division of Vital Records, P.O. Box 68760

Exami Physician/Medical IF FFMALE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be မ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier (Check 3 E 29b. Signature and title of

9 Unknown

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. . License numbe

ER/Outpatient 3 DOA

28b. Time of

10033280

1 Yes 2 No

Other:

28c. Injury at work?

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) 21 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an

4 Nursing Home 5 Residence 6 Other (Specify)

autopsy performed? Yes 2 No

28d. Describe how injury occurred

21502

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD Sunil K. Gupta, M.D.,

31. Date filed (Month, Day, Year)

22 2012

32. Registrar's Signature backe

1 Inpatient 2 I

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of N	Maryland	-	artment of H <i>tificate of D</i>		ı Mentai Hy	giene Reg. No.	2012	35189
	Dhuniaia		Registrar 1. Decedent's Name (First, Middle, La	,			imouto or D	-	2. Date of De	eath		3. Time of Death 06: 20 M
	Physicia Medic	al	Harry 3 4a. Facility Name (if not institution, give	Felice GR		rT	4b. City, Town, or	Location of De	Octobe	4c.	County of Deat	th
	Examin		Homewood at Will	iamsport			Willia	msport		W	lashing	ton
H	Funeral Director		106 00 550/				If Under 1 Year Months Days	If Under 24 H Hours M		ay, Year)	Co	thplace (State or Foreign untry) nsylvania
	how #	ž	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation		APILI	14,12	/14	10d. Inside City Limits
	Marylar 28a-f s	irect	Maryland Washing	ton	Fai	r Play						1 ☐ Yes 2 ♣ No
	with the 23a or	Funeral Director	10e. Street and Number 8927 Jordan Road	l			10f. Zip Code 217	33		10g. Citi	zen of What Co U.S.A.	ountry?
920	parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1 🖾 Yes 2 If Yes, Give Year or Dates	s? □ No 194	+3	Was Decedent of His f Yes, specify Cubar I ☐ Yes 21 No		(Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, Whit Specify: wh	
15-0	72 hour	Completed	15. Decedent's (Specify only highest g	rade completed)	Ù.	(Give	dent's Usual Occupa kind of work done d O NOT use retired)	uring most of v	vorking		nd of Business	
212	within glana.		Elementary/Secondary (0-12)	College (1-4 o	or 5+)	Manpo and p	O NOT use retired) wer devel rocuremen					vernment
and	ba filad antal Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) $Ortenzio D.$		etti				Name <i>(First, Middle</i> cia Bevac		Surname)	
Maryland 21215-0036	12 should alth and Ma 27 is mar ir traumati		19a. Informant's Name/Relationship (n	19b. Maili 8927	ng Address (Street a	and Number or oad, Fa	Rural Route Numb	er, City or Mary	Town, State, Z 1and 2	ip Code) 1733
Baltimore,	Paga 1 and mant of Hadant: If Itam ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	cify)	ate ce	metery, crer	osition (Name of matory or other plac vn Cremat	ory Oc	Date tober 25 2012	Hag		n, Maryland
Balt	parmit. Depart Import any Inj once.		21. Signature of Puneral Service Lice	nsee Carlo			2. Name and Addres L5 East W	ss of Facility ilson B	Minnich lvd., Ha	Funer gerst	al Home own, Ma	e aryland 21740
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Same	Examiner	ě	Sequentially list conditions,	b. Due to or	as a conseque	ence off:						
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Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)								lural Route Number,	
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	To the within 7	2	29b. Signature/architecture 29c. Libense number 29d. Date signed (Month, Day,									
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2012	gistrar's Signat	ture .	have					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Çertificate of Death PER FH IM 2. Date of Death 3. Time of Death Physician/ Medical $10^{th} 15 - 20^{2y} 2$ 15:58 P M MINNIE GERTRUDE GARDNER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON PGSOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 245-58-4593 76 **Director** 1 □ M 2 🗓 F Vrs 6-29-1936 NC Usual Residence of Dece or 28e-f show 10d. Inside City Limits 10c. City, Town or Location rei", or items 23a or 28e-f sho 10a. State rector within 72 hours after death with the Maryland SEAT PLEASANT 1 Yes 2 □ No MD PG ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 US 404 71ST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ξ Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify "naturei", 3 Widowed 4 ☐ Divorced Completed BLACK the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportent: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AMES POLLARD AMOS POLLARD DECIE LEARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINNIE VINSON/DAUGHTER 10921 MARYLAND WOODS CT., WALDORF, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10-20-2012 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Se 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fullure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Microscleroff Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sicien and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physicien page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy 5 Other (specify) Month Day Year g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. • Funeral Director: After this certificate has t etely filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မှ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D72121 污剂 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503, SURRATTS RD, CLINTON, MD 20735 BOI TRAN, M. D 31. Date filed (Month Day) Yes Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sctober Day Roland L. Gonzales, Jr. 14, 2012 9:40 PM Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's aurei Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month Day Year Hours Director 577-46-3400 1 🛛 M 2 🗆 F 78 Yrs. 09/29/1934 Washington, DC 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director be notified 1√2 Yes 2 □ No Maryland Prince Georges Lanham 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8909 Orbit Lane 20706 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Force Black White etc "natural", or þ 1 Never Married 2X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White If Yes, Give Completed 3 Widowed 4 Divorced Vear or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Messenger Self Employed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or traumatic even Roland L. Gonzales, Sr. Virginia Tolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Thomas Gonzales (Son) 135 Pineview Dr. Front Royal, Va. 22630 item 2 20a. Method of Disposition
1 □ Burial 2X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. ò 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/17/2012 | Beltsville, Maryland 22. Name and Address of Facility Rendon/Hale Funeral Home Signatu f Funeral Service Licen 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 1 Septicemia Medical Examiner rneumonia Sequentially list conditions, if an , leadin , to immediate cause. Enter Underlying Examine Due to jor as a conse juence of Cause (Disease or injury by the attending physician and etached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death
Pregnant at time of death should be detached for in the past 12 months? Month 2 No Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease Hemodialysis on 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been Coronary Artery Disease status post Coronary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy Artery By-Pass Graft perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 **X** No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No the Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) ててじん かいん DUU 57216

Registrar

State

Regional

Hospita

PITTSICIAS

32 Registrar's Signature

Laurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baako, M.D.

15

7300 Van

Laurel

Dusen Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month [Physician/ 7:20 AM Patricia Ann Gatton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at Wicomica Salisbury Like st. Social Security Number If Under 1 Year I If Under 24 Hrs. 6 Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 1 F April 16, 1939 Pennsylvania Director 73 203-30-4729 Usual Residence of Decedent 28a-f shov 10h County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 X No o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 207 Pacific Avenue 21804 U.S.A. items ; 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married 2 No 1959-Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) atricia marked ပ Frank Donnick Katherine Lochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 st Department of Health a Important: If item 27 is Donald T. Gatton (Husband) 207 Pacific Avenue Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Crematory of Delmarva 10-15-2012 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signature of Funeral Service Licensee Shame and Address of Facility Short Funeral Home 13 East Grove Street any 19940 Delmar, DE 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed -tran Due to (or as a consequence of): burial-Physician/Medical Box 68760 phys the L nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, fo the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s Jas autopsy performed death? certificate I ☐ Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending □ Accident 1 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signatu Name and address of person who completed cause of death (Item 23a) (Type, Print) \$2. Registrar's Signature State 2012

Registrar

Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar		State of	iviai yiaii		ertificate of E		- wientann	Reg. No	-211	12	35193
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°Funeral		5. Social Security Number	6. Sex	7. M 2 X F	Age (In yrs. Ia			If Under 24 H		irth		9. Birth	place (State or Foreign
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and show lat	or		County		10c. City	, Town or l	_ocation			·			10d. Inside City Limits
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or iter	by Ft	11. Marital Status1 ☐ Never Married 2		 Was Decede Armed Force Yes 2 	s?	5.	 Was Decedent of Hi If Yes, specify Cuba 	ispanic Origin? (in, Mexican, Pue	erto Rican, etc.))		ce - Americ ck, White,	can Indian, etc.
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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at		EARL R. GWIN		ON	205 0		48 AZELEA position (Name of	RD., BE					
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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra once.		4 Donation 5 21. Signature of Junerar S	Other (Specify)	2//	YREM		OF DELMAI 22. Name and Addres		15/12	DELL	MAR,	DELA	WARE
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 16 Physician/ 201^{rea} 9:25 A^{M} Edgar Leslie Gott, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Asbury-Solomons Health Care Center Solomons If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 220-16-5384 **Director** 1 🛚 M 2 🗆 F 07-25-1924 Maryland Usual Residence of Decedent 88 28a-f shov 10d. Inside City Limits 10c. City, Town or Location Director must be notified 1 ☐ Yes 2 X No MD Solomons Calvert 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number Funeral items 23a USA 11450 Asbury Circle 20688 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Year or Dates. 1943–45 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Government College (1-4 or 5+) Elementary/Secondary (0-12) Electronic Technician Naval Research Lab Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Eliza Iola King John Hutchins Gott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 281, Prince Frederick, MD 20678 Linda J. Horsmon, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Harmony Cemetery 10-18-2012 Owings, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD MO0715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Poset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

and address of person who

31. Date filed (Month,

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completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatur

WEI GEZ

OCTOBER 16,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3 ^{Yea}12 10 5:20 Stewart Wesley Gahagan Sr. Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours 81 4/19/1931 **Director** 212-30-2896 MD Usual Residence of Decedent show 10a, State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 280 Arundel Lane USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injuy or other traumatic evea once. Cloy Gahagan Pauline Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Gahagan / wife 280 Arundel Lane, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/18/2012 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Rising Sun, MD 4 Donation 5 Other (Specify) Foard Funeral Home, P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 unard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Cancer Una disease or conditi-resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No Yes 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director, After 1 Natural 5 Pending injury 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

2

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGUSTINE

MD

HERMAN

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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SHAHWAWAZ KHANMD

29d. Date signed (Month)

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HWY, SUITEA, CHESAFEAKECITY, MD 21915

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Day, Year)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35 1 - State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ earl Haigler 2012 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Manor Care Health Services Largo 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 227-46-3338 Director 1 M 2 F South Carolina 90 -23-1922 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Prince George's Springdale MD 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 2801 Berry Wood Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Private College (1-4 or 5+) Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Julia Johnson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 2801 Berry Wood Lane Springdale, MD 20774 Donna Davis/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other p. 20a. Method of Disposition 20c. Location - City or Town, State 0 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Metropolitan Crematory 10/15/12 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral, Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician) Lavaincea disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2XXNo Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ertension 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an obstractive pu chronic has page 2 autopsy perform ours after death.

eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🐼 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number D51520

Registrar
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WASHINGTON, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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62. Registrar's Signature

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31. Date filed (Month, Day Year)

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Physician/ Medical Examine	Decedent's Name Howard	Washing		orseman				2. Date of De Month October	Day Year 11, 2012	3. Time of Death 1155 hrs
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any	Usual Residence of I	Decedent 0b. County		10c. City, Tow	n or Location					10d, Inside City Limits
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Baltimore, permit. Pages I an Department of Hee Important: If ite	4 Donation 5	Cremation 3 Other Specify:		ale	sbury C	remato	_	0/15/20		
Balt permit Depart Import	21. Signature of Fun	eral Service Licensee			Holl Holl	and Addres	uneral	Home Pro	ofessional A	Association
Physician		disease, or complica one cause on each		the death. Do	not enter the m	ode of dying	, such as cardiad	or respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (F		ultiple Injuries to (or as a cons							Death
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Division of Vital Records, P.O. Box 68760, within 24 bound and Physician: The law requires that the death certificate be exwitin 24 bouns after death. To the Faneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial endical Certification: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent p past 12 months?	oregnant in the	23c. If yes, outco 1 Live birth 4 Pregnant a 9 Unknown		2 Fetal d	eath 3 (Specify)	Ectopic preg	gnancy	23d. Date of delive Month	ery Day Year
P.O. B is that the digned by the detached is		icant conditions co		h but not resul	ting in the unde	rlying cause	given in Part I.		tobacco use contribute t	
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on of Vi ading Pbys th. : After this e funeral di	27 Manner of Death	No Pending	28a. Date of Inj Oct 11, 2012	ury 28 (eer) 11	b. Time of Injury		ury at Work? Yes 2 ✓ No		e how injury occurred bickup which struck	fixed object
Division o Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Afth completely filled in by the fune	2 Accident 3 Suicide	Investigation 6 Could not be	28e. Place of I	njury - At home	, farm, street, fa	actory, office	building, etc.	or Town	(Street and Number or F	
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To the HG within 24 To the Fu complete!	(Check only one) 2	Medical Examiner: O	n the basis of exa nd manner stated	amination and/o	or investigation,	in my opinio	n, death occurre	d at the time, da	te and place, and due to	the cause(s)
F > F 5	29b. Signature and	title of certifier	0-00	7		29c. Licen	.M.E.		29d. Date signed (M October 12, 20	
1107	30. Name and addre	ess of person who con	npleted cause of	death (Item 23	a)					
HBI	Patricia Aror	nica-Pollak MD.	Assistant I	Medical Exa	aminer 90	0 W. Balti	imore Street	, Baltimore,	MD 21223	
Stat Registra		16 2012	32. Registr	ar's Signature	parker				- <u>.</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:05 A M Diane Marie Harrington 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death at the call Dice omico If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 394-42-0344 Usual Residence of Decedent 1 M 2 K F 04|02|1943 Wisconsin 69 or 28e-f shov 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director <u>Delawa</u>re | Sussex Delmar 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 19940 USA 406 Lincoln Ave and Mental Hygiene. Is marked other then "naturel", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Baltimore, Maryland-21215-0636 1 Never Married 2 Married δ 1 ☐ Yes 2 X No Specify: If Yes Give 3 Nidowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Doctors Office Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ida Tilkens Rav Gonnering 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Importent: If item 27 eny Injury or other tr 1701 West Clear Lake Dr., Salisbury, Maryland 21804 Lisa Jones daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10 12 2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 Keleck 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ AMYOTROPHIC SCLRROSI_ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami anding physician and use as the burial-transit or Attending Physicien: The lew requires thet the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the attending posterior that the state of th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 pronths?
1 Yes 2 No
9 Unknown 5 Other (specify) detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No Yes 1 🗌 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 105PI 3= ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAM V 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tobe Daniel Leroy HINES 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 220-66-9452 Director 1**X** M 2 □ F 56 Sept.6,1956 D. C. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13617 Lois Street 21740 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White, etc. Completed by 1 X Never Married 2 Married 2 🛛 No 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) roofer roofing contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil f Health and Mental item 27 is marked ဂ္ William Hines Wilma Edith Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma E. Hines - mother 13617 Lois Street, Hagerstown, Maryland 21740 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 10/17/12 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Sign of Funeral Service Licen 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ACUTE HYPOXIC RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPTIC SHOCK SECONDANY TO PNEUMONIA Dequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit RENAL WIE and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Pregnant at time of death Day 2 should be detached Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe certificate Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MID D70607

Registrar

DHMH 17 Rev 06-2011

State

Medical Campus Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT

MD

11116

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Margaret Marie Haupt October 5:09 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21437 Greenbriar Road Boonsboro Washington 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Director 215-18-2688 1 🗆 M 2 🗶 F 89 Nov 19, 1922 Maryland Usual Residence of Deceden or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Maryland Washington Boonsboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a 21437 Greenbriar Road 21713 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Head Cook Nursing Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 7 is marked o ပ Carlton Luther Minnick Lydia Byrem Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 21312 Greenbriar Road Boonsboro MD Allan Haupt / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 10/15/2012 Boonsboro, Maryland ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral 20 ice Licen 22. Name and Address of Facility Bast-Stauffer Funeral Home P.A. 7606 Old National Pike Boonsboro MD 21713 23a. Part 1. Poter the disease, or complication shock, or heart failure. List only one cause s that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and ach line. Interval Between Onset and Death Immediate Cause (Final End Stage Dementra Physician disease or condition resulting in death) lears Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exam that initiated events and use as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen s Cardiac Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barb Spencer, CNP 747Northern Avenue Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patrick Neal Harris 320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany WMHS Regional Medical Center Cumberland 8. Date of Birth (Month, Day, Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 216-96-1541 1 🗶 M 2 🗆 F 47 October 08, 1965 Maryland Usual Residence of Dec or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Uhl Street 23a Funeral 21532-U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 0 Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Kenneth Harris Mary Alice Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i Mary Alice Harris Mother 38 Uhl Street Maryland 21532-Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗶 Burial 2 □ Cremation 3 □ Removal from State Frostburg Memorial Park October 23, 2012 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Inhola Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition DYVIUMONICA Medical resulting in death) Due (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ď 4 Pregnant at time of death 9 Unknown Month Day Year the a 9 Unknown Division of Vital Records, P.O. signed by to d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy bage performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at I Director: After the din by the funeral Certificate: (Month, Day, Year) 5 Pending work? 1 Natural Accident 2 🗌 No hours after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C completely filled To the Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10. 22, 2012 MO 072514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Rd Cumberland, MD, 21502 TIKS 19200 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Hamilton Physician/ Catherine Mae 12, 8:55 A M Oct. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 914 Copley Ave. Waldorf 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 219-54-7488 **Director** 1 🗆 M 2 🔀 F 101 Yrs. 12/19/1910 Maryland 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland notified at Director Waldorf 1 Yes 2 No MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral United States 20602 914 Copley Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No s, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic even ည William Murdock Hodges Mae Gertrude Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Woolard/Daughter 914 Copley Ave., Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gds. 10/18/12 Waldorf, MD 22. Name and Address of Facility Raymond Funeral Svc. 21. Signature of Funeral Service Licen 20646 M01517 5635 Washington Ave., La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DVBW Physician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for Month Day Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been significate has been significated funeral director, page 2 should be Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination y opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: to the best of m knowledge, death occur ed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 0540 AM Robin Lynn Holding Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Ceci1 Laurelwood Care Center E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0CT 30, Year 958 1 M 2 TF Maryland 53 220-74-3756 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 No Maryland Ceci1 E1kton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 100 Laurel Drive 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Betty Lipford James R. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 W. Red Lion Drive, Bear, James R. Wood/Father DΕ 19701 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Gifpin Manor Memorial Park ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 4 Donation 5 Other (Specify) 22. 2012 Elkton, MD 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardio reshira disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? ombl s after death.

Director: After this certificate Non C CAMLEY 2 No 1 Yes 2 No arian 25. Was case referred to medi al 26. Place of Death (Check only one) funeral director, Be examiner? 1 ☐ Yes 2 KNo Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of **Certificate:** 28c. Injury at 28d. Describe how injury occurred work?
1 \[\text{Yes} 2 \[\text{No} \] iniury 1 🔀 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammed N1a2-107 N. Bridge

32. Registrar's

29c. License number

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death Physician/ Ruby Eileen Haines Oct. 15, 2012 17:20PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery If Under 1 Year I If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours **Director** 232-62-5899 74 Yrs. 1 M 2 XF July24,1938 WV er than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cabin John 1 🗆 Yes 2 🔀 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6525 77th St. 20818 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۵ 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 permit. Page 1 end 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "naturel", eny injury or other traumetIc event, the Medical Exar 1 ☐ Yes 2 😿 No Specify: Completed 3 Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Delivery Service Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Hetzel Taylor largent Verna Estella Cowgill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Ann Haines (daughter) 1118 Alben St. Durham, N.C. 27713 20b. Place of Disposition (Name of cemetery, crematory or other place)
Branch Mt.
Baptist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/19/12 Three Churches, W 21. Signature of Funeral Service Licerse 22. Name and Address of Facility McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit End Stage Renal Disease Due to (or as a consequence of): resulting in death) Last Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗆 Yes 2 🗀 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 ☐ Yes 2 Ø No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 66264 10/16/12

Registrar
DHMH 17 Rev 06-2011

State

Bethesda, MD 20814

8600 Old Georgetown Rd.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babak Pirouz MD

MOV 0 2 2012

31. Date filed (Month, Day, Year)

12-07713 Jeffery Wayne Hyde Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

ellely wayle i		1-For State - Certificate of Dea			2 U 1 C	33200
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death 2008 hrs
nedical Exami	ner		y, Town, or Location of Deal	Month October 11	, 2012 4c. County of Death	2008 rirs
			llaway		St. Mary's	
Funeral			nder 1 Year If Under 24Hr	_	n(MM/DD/YYYY) 9. Birti Foreigi	
Director		217-98-6285 1x M 2 F 34 Yrs.	Itilis Days Flours Wil	10/17	/1977 Col	intry) MD
aoy.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			T	10d. Inside City Limits
	ъ	MD St. Mary's Callaway				1 Yes 2 No
nth the Maryland 23a or 28a-f show eotified at once.	Director	10e. Street and Number 10f. 2	Zip Code	10	g. Citizen of What Coun	try?
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urs after death w ural", or items	by Ft		2 No specify:		Specify: Whi	
hours natur		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu during most of y	ual Occupation (Give kind of working life. DO NOT use re	f work done etired)	16b. Kind of Business/Ir	ndustry
36 hin 72 te. than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Truck D	river.		Tayman Tr	ucking
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic evect, the Medical Examiner must be softlied at once		17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
121 Id be fi Jental narkec	To Be	Joseph Hearld Hyde, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	ess (Street and Number or		Buchanan Der City or Town State	Zin Corle)
MD 2 id 2 show lith and M m 27 is n	F	11111	Rhodes Av			
re, F s 1 and f Healt ff item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Notermatory or other plants)		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4. Donation 5 Other Specify: Metro. Cre	ematory 10			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 he Department of Health and Montal Hygiene. Important: If item 27 is marked other than "minjury or other traumatic evect, the Medical Expense.		22. Name a MO 1517 5635	nd Address of Facility Ra	-		
Physician	0.5	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod				Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Morphine Intoxication				Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):				
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1876 tificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3 Ectopic pregr	nancy	23d. Date of delivery Month D	ay Year
OX 6	Physician/	4 Pregnant at time of death 5 Other (S	pecify)		i.e.	ı
that the derected for		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
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cords, law requir has been s	plete			24a. Was a autops	y prior to co	opsy findings available empletion of cause of
tal Recciao: The la	Completed			perform 1 Yes 2	ned? death? ☐ No 1 ✔ Yes	2 No
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Atteodiog Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated.				
HSHS	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		20 North delegan of paggoon the paggoon of the state of t	O.C.M.E.		October 12, 2012	
		30. Name and address of person who completed acuse of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. B	altimore Street, Baltii	more, MD 212	23	
	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature		001	JE	
Regis	trar	THUY UNGULA (MANAGE) AND PROPERTY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland /	Depa	artment of H	Health an	d Mental Hy	giene 20 I	2 35207
			Registrar 1. Decedent's Name (First, Middle)	, Last)			Till Cate Of L	Jeann	2. Date of De	Reg. No.	3. Time of Death
	Physicia Medic		GLADYS	ITS	UOKOR				Month 10- 08	B-2012	
·*· .	Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	Location of D		4c. County of D	
24	_		10112 ELLARD DR 5. Social Security Number		e (In yrs. last b	isth day)	LANHAM If Under 1 Year	If Under 24 I	dre Lo p.u. (P)	PG	
	Funeral Director		213-37-0678	1 D M 2 F	47	Yrs.	Months Days		1 8. Date of Bir 1 (Month, Da 8-28-19	v. Year)	Birthplace (State or Foreign Country)
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County				<u> </u>		0-20-13	NIC	GERIA
	arylan a-f sh fied a	Director	MD PG		10c. City, To		cation				10d. Inside City Limits 1X Yes 2 □ No
	or 28 e noti	١	10e. Street and Number				10f. Zip Code		1	10g. Citizen of What	
	s 23a	Funeral	10112 ELLARD DR	RIVE			2070	6	Ì	NIGERIAN	
	death r item iner n		11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ai Black, W	merican Indian,
980	s after al", o Exam	d by	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀 No	Specify:		SpecifyAFI	
2	be filed within 72 hours after death with the Maryland antal Hyglene. ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	Completed	15. Deceden	t's Education st grade completed)	16		ent's Usual Occup			16b. Kind of Busine	ss/Industry
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an	be fill lental rked c	10	Joseph Omorodio	,					ia Uwadia	ivialden Sumame)	
lary	should be file and Mental is marked of raumatic eve	104	19a. Informant's Name/Relationsh	ip (Type, Print)	19	9b. Mailin	g Address (Street a	and Number or	Rural Route Numbe	r, City or Town, State,	Zip Code)
≥,	ind 2 selection in 27 sector in		MATTHEW ITSUOKO	R/ HUSBAND	_ 1	0112	ELLARD	DRIVE,	LANHAM, M	D 20706	
סר	Page 1 ament of Hant of Hant; If ite		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	20b. Place cemet	of Dispostery, crem	sition (Name of latory or other plac [ON	e) 1.0	Date 20 12	20c. Location - City	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (State of State of S		CEMET				-20-12	CLINTON,	
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Vital Records,	w requisited is been 2 shou	Completed							24a. Was a		autopsy findings available
ě	The la ate ha page	E							— autop perfo 1 ☐ Yes	rmed? death	o completion of cause of ? /es 2 No
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5	ortal or urs aff ral Di								City or Tow		
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	ZIM		30. Name and address of person w	//			int)				
	State	P.	THOMAS BENSINGE		21 GRE	ENWAY	CENTER	DR., G	REENBELT,	MD 20770	
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		•	For State Registrar	State of Maryland		artment of Hea <i>tificate of Dea</i>		l Hygier Reg. I	21117	35208	
	Dhusisia	-/	Decedent's Name (First, Middle, Last	")			2. Date	of Death		3. Time of Death	
	Physicia Medic	al	Robert William Ja	- ·-			10 15/201			9:47 Р м	
-	Examin	er	4a. Facility Name (if not institution, give s 456 Dueling Way	street and number)		4b. City, Town, or Loc Berlin	ation of Death		ac. County of Dea Norceste:		
	Funeral Director		213 28 /322	x ▼ M 2 □ F 7. Age (In yrs. last 82	st birthday) Yrs.		Under 24 Hrs. 8. Date ours Min. 9/1/	of Birth th, Day, Year 1930	g. Bir MD	thplace (State or Foreign untry)	
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Worceste	r Berlin						10d. Inside City Limits 1 1 Yes 2 □ No	
	s 23a or 2 s ust be no	Funeral Di	10e. Street and Number 456 Dueling Way	*		10f. Zip Code 21811		10g. US.	Citizen of What Co A	ountry?	
9800	ye 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🏿 No Specify:			14. Race - Ame Black, Whit Specify: Wh	e, etc.	
Maryland 21215-0036	thin 72 hou sne. than "nat u he Medic a	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Seconday (0-12)	de completed)	(Give life. D	dent's Usual Occupatior kind of work done durin O NOT use retired) ighter			Kind of Business	Vet.Hosp.	
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	d 2 should be fil alth and Mental 127 is marked or er traumatic ev		19a. Informant's Name/Relationship (Ty) Suzanne Jackson (Number or Rural Route I			p Code)	
Baltimore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hopewell Cemetery 20c. Location - City or 7 Rising Sun, 21. Signatury Functor Service License 22b. Name and Address of Facility The Burbage Funeral Figure 1 Service License								
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	ulas-			Facility The Burst. Berlin			Home	
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Div.	ital or variatel radio or variatel		4 Hornicide determined	building, etc. (Specify)			City	or Town, Sta	rte)		
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D	N /6+1		30. Name and address of person who co				rack fo	UNIT	c Berl	ump ZIYI	

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State Registrar park

31. Date filed (Month, Day, Year)

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/13/2012 Edward James, Jr. 2240 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 250-07-2006 Director 98 1 XM 2 | F 09/15/1914 SC Usual Residence of Decedent iral", or items 23a or 28a-f shore Examiner must be notified at 10a, State 10b. County within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director Charles Waldorf 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 6112 Red Squirrel Place 20603 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1943–1946 Year or Dates. 1 ☐ Yes 2 ➡ No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 el Hyglene. Elementary/Secondary (0-12) 8 t h College (1-4 or 5+) Painter Federal Government permit. Pege 1 and 2 should be filed wit Department of Heeith end Mentel Hygle Importent: If item 27 is marked other t any injury or other traumetic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward James, Annie McClain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twona Brown/niece 6112 Red Squirrel Pl Waldorf, MD 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date Gate of Heaven Cem 10-18-12 1 Surial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Priscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTRO INTESTINAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine lany, leading to incrediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit POTEX Hospital or Attending Physician: The lew requires that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical DISSASS Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day ☐ Pregnant at time of death 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an prior to comp death? autopsy performed? 2 X No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of opposition and/or invariant and of the cause of opposition and/or invariant and of the cause of opposition and/or invariant and of the cause of opposition and/or invariant and of the cause of opposition and/or invariant and other cause of the cause of opposition and other cause of the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier death (Item 23a) (Type, Print) ame and address of person who completed cause ROAD CLINTON 20734

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ essec rene 0236AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Washington 19800 Tranquility Circle Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 10-11-1931 Hours 215-26-8375 Min 81 Frederick MD **Director** 1 🗆 M 2 🗶 Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director Washington Hagerstown 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be n Funeral 21740 19800 Tranquility Circle U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by 21215-0036 Specify: white 1 Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) residence Flementary/Secondary (0-12) 7th grade College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the A once. Homemaker Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Annie Crum 17. Father's Name (First, Middle, Last) Lester Harrison Rippeon 19a_ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12921 Keefer Rd. Big Pool, MD 21711 Steven Jessee son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 10-17cemetery, crematory or other place)
Cedar Lawn Cem. 1 Waurial 2 Cremation 3 Removal from State Hagerstown, MD 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Lice 2. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Anset an, ath 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 🗌 No this certificate 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural Accident 5 Pending ours after death.

neral Director: Af
filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Hospital Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, Print MD erstown

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:25 P. M 2012 CTOBER Ruth Lorraine JUDD 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Reeder's Memorial Home Boonsboro Washington 1 Year If Under 24 Hrs. 8. Date of Birth If Under Date of Birth (Month, Day, Year) 6 1<u>920</u> Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday. Months Hours 1 M 2 F Yrs Ma<u>ryland</u> Oct. 213-18-9325 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 17964 Garden Lane 21740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 X Yes If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 1944-47 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Spence Ora Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Chancery Street, New Bedford, Mass. 02740 Julia Seguin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/15/2012 Hagerstown, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Na 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Signaturalizity ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed physician a the burial-t Division of Vital Records, P.O. Box 68760 attending pl for use as t signed by the a been si this certificate has ral director, page 2: within 24 hours a

Physician/

Medical

Director

Completed by Funeral

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Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shorexaminer must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other them."

Physician/

Medical

Examiner

Examiner

dical		d				
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
ed by Pi	Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Perobably 4 Unknown				
Complet			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 □ No			
Be (25. Was case referred to medical	26. Place of Death (Check	only one)			
일	examiner? 1 Yes 2 × O	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ne 5 Residence 6 Other (Specify)			
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	8d. Describe how injury occurred			
edical Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medica	(Check 2 Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at see Practioner: To the best of my knowledge, death occurred at the time, date and places.	the time, date and place, and due to the cause(s) and manner stated			

29c. License number

00632

HAGERSTOWN

State Registrar

JW-4+1

MAHMOOD 580 NORTHERN 32. Registrar's Signature

31. Date filed (Month, Day, Year) 6 2012 OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 13 201^{rea} Phillip Leroy JONES 10:31pм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 10906 Clinton Avenue Hagerstown 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Nov. 18, Year 1938 Maryland 220-34-0389 73 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 10906 Clinton Avenue 21740 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic account the than "n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1956 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced Completed 1964 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) assistant professor university Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Janice Irene Hook Dewey Leroy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10906 Clinton Avenue, Hagerstown, Maryland 21740 Gloria J. Jones - wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee Calent 415 East Wilson Blvd., Hagerstown, Maryland 21740 TB. Can 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Coronary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Zyears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ☐ Pregnant ☐ Unknown Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 No 3 □ Probably 4 □ Unknown Completed Parkinson's disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 22911

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jefferson Blud Smithsburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James Edward Jianniney, Sr. October 0 10 2012 10:04 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 19 Cemetery Road Ceci1 North East 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral 1XX**M 2 □ F Months Days Hours **Director** 24.1943 218-40-7075 69 March Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil North East 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Cemetery Road <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married XX Married 2**XX**No þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ Road Maintenance County Roads Department should be filed with and Mental Hygien 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Fort Jianniney traumatic Ruby Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Phyllis Jianniney / Spouse 19 Cemetery Road, North East, Maryland 21901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State North Fast United Methodist Cemetery October 15 1 X Burial 2 Cremation 3 A Removal from 4 Donation 5 Other (Specify) 2012 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home, P.A. Ch 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

A DUF 70 LARYNGEAC 03. OBSTRUCTION Onset and Death Physician from a freelyn Buon Medical resulting in death) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin transit d Due to (or as a consequence of) nding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, 2No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 1 🗌 Yes 2 🗆 No this certificate Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\text{XResidence} \) 6 \(\triangle \text{Other} \) Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred thin 24 hours after death.

the Funeral Director: After impleted filled in by the funeral Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier (🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

8

Sute 310

MD

HIGH Street
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

FZKRN. MD 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ October 2012 A M0830 Catherine L. Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Calvert Manor Healthcare Center Rising Sun Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 221-09-3964 **Director** 1 □ M 2 🗓 F DEC 21, 1911 100 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No Delaware Sussex Lewes 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19958 United States 21263 Alligator Alley 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed withi and Mental Hygiene 7 is marked other th Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Drummond Helen Keethley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health a 21263 Alligator Alley, Lewes, DE William Donald Dunn/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October permit. Page 1 Department of Important: If ii any injury or or cemetery, crematory or other place, 1

Burial 2

Cremation 3

Removal from State A. Ferris & Co., Inc. 10, 2012 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee Þ 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death NON-SMALL CELL GARCINOMA OF CHEST WALL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** cuantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 morths? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death 2 12 No g Unknown the g Unknown Division of Vital Records, P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribate to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has perform death? eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifig 00063460 110/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILL DRIVE VILLAR, MD VANESSA MD 2192

Registrar

31. Date filed (Month, Day, Year)

NOV 0 2

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 18, 2012 9:40p M June Palmer Kunkleman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport.
If Under 1 Year | If Under 24 Hrs. Washington Homewood At Williamsport Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Min. 100-12-0812 Director 1 □ M 2 🕅 F 87 02/23/1925 Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 16505 Virginia Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the N Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Inez Kathleen Moore William Linnwood Mahone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19107 Woodburn Court, Hagerstown, MD 21742 <u>Pamela K. Mumma / Daughter</u> Baltimore. 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or oth cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 10/23/2012 4 Donation 5 Other (Specify) Hagerstown, MD Haven Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the meath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseq Exami attending physiclan and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Vear 2 3 No g 🗌 Unknown g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed this certificate has been sirral director, page 2 should ' 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phe within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina work? 1 ☐ Yes 2 ☐ No Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date/signed (Month. Day, Year) 201 and addre

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Allan Dean Katzenmaier 19:58 P Medical 2012 Oct 9 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 T11:poi **Funeral** Days Hours Illinois 333 26 1291 Director 1 X M 2 □ F 78 May 14, 1934 Summerville, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mary Land Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7400 S. Osborne Road 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ≥ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Completed Year or Dates. 1951–1971 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. d other than "I Elementary/Secondary (0-12) College (1-4 or 5+) 8th U.S.A. F. Sr. MSGT U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 2 William Charles Katzenmaier and 2 should b Health and Mea tem 27 is mark Mary Novella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Polansky - Daughter 4155 Georges Way, Boca Raton, Florida 33434 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Page Maryland Veterans Cemetery 10/20/2012 4 Donation 5 Other (Specify) Cheltenham. MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service License Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 for use as the IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached 9 Unknown o 至 s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 - Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Griffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / [Depa <i>Cer</i>	ırtment of H <i>tificate of D</i>	lealth and I Death		jiene 2 Reg. No.	2012	35217
	Physicia	n/	1. Decedent's Name (First, Middle, Las		T T				2. Date of Dea	th	Ž612	3. Time of Death 12:07 AM
4-	Medic Examin	al	SAMUEL EGBER. 4a. Facility Name (if not institution, give		<u> </u>		4b. City, Town, or			_	ounty of Death	-
ممس			1 TERESA AVENUE 5. Social Security Number 6. S	ov 17 Ag	e (In yrs. last birt	hday)	RISI	NG SUN	8. Date of Birth		CEC	IL place (State or Foreign
	Funeral Director		313-26-4475	XM 2 G F		Yrs.	Months Days	Hours Min.	SEPT Date of Bill	8 , 192	26 ILL	TNOIS
	and show fat	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation		· -			10d. Inside City Limits
	Maryl. 28a-f notifie	Jirect	MARYLAND CECIL 10e. Street and Number		RISIN	G SI		_				1 X Yes 2 No
	with the	Funeral Director	1 TERESA AVENUE				10f. Zip Code 2191	1			n of What Cou FED STA	
036	e filed within 72 hours after death with the Maryland tal Hyglene. de other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	Ever in U.S. No	lf	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, WH	
215-0036	72 hour "natur edical	Completed	15. Decedent's E (Specify only highest gr		16a	(Give k	ent's Usual Occupa	ation Juring most of wor	king	16b. Kind	of Business In	dustry
717	within a giene. Ser than the M		Elementary/Seconday (0-12)	College (1-4 or 5	5+)		NOT use retired) INISTER			RI	ELIGION	
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) HENRY FRANK KUY	KENDALL					ne (First, Middle, I		rname)	
Maryland	should and Mi is mar aumati	1	19a. Informant's Name/Relationship (10.0		g Address (Street a					
	1 and 2 if Health item 27 other tr		CHRISTINE JOY COR	DERO/DAUGH	20b. Place o	f Dispo	JTH FRIEN sition (Name of				ARYLAND ation - City or T	
Baltimore,	. 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		KUYKE	NDA1	LL CEMETE	KY 20	BER 10,		I, ILLI	
Ball	permit. Page Department i Important: Ii any injury or		21. Signature from I Sevin 3 on	ee			Name and Addres					.A. LAND 21901
4	Physician/ Medical	With the same	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Deme	е.	not ente						Approximate Interval Between Onset and Death
	Examiner	ier	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):						
	outed nd rransit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	c		-0:			_			
5	icate be executed physician and sthe burial-transit	edical E	resulting in death) Last	d.	a consequence	01).						
09/89	rtificate ling phy e as the	/Med	IF FEMALE:	220 If you guitanma	of processor							
). Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	very Day Year
ds, P.O.	equires that sen signed be ould be deta	Ş	Part II. Other significant conditions	contributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.		/es 2 🗗	No 3□Pro	the cause of death?
Vital Records,	n: The law re ficate has bi ir, page 2 sh	Completed	25. Was case referred to medical				ne pl	ass of Dooth /Cho	1 🗌 Yes	rmed?		opsy findings available ompletion of cause of
Vita	nysician lis certii directo	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ER/O	utpatier	_ Othe	ace of Death <i>(Che</i> er: 4 Nursing F	lome 5 Resid	ence 6	Other (Specif	jy)
n of	iding Pl th. After th funeral	cate:	27. Manner of Death 1 M Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Da		Time of injury	28c. Injury work M 1	/ at ? Yes 2 □ No	28d. Describe h	ow injury o	ccurred	
Division of	or Atter after dea Director: in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	De 28e Place of Ini		arm, stre	eet, factory, office	_	28f. Location (S City or Tow		lumber or Rura	al Route Number,
	e Hospital 24 hours e Funeral eleted filled	Medical	(Check 2 Medical Exan	vsician: To the best of niner: On the basis of e rse Practioner: To the	examination and/	or invest	tigation, in my opinio	on, death occurred	at the time, date a	nd place, ai	nd due to the ca	ause(s) and manner stated.
		-	29b. Signature and title of certifier	10-6. 1			29c. License				signed (Month,	
	5		30. Name and address of person who	Completed cause of		(Type, F		04437	>	10	108/	2012
			Joseph K Weidn 31. Date filed (Month, Da)	er,Jr 101				ng Sun, l	Maryland	2191	1	
	Sta Registra		On Date med (Workin, Day Col. ()	9 20 12 ^{2. Regist}	ars signature	Ø.	parked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 10 04 2012 21:32 P M William T. Knott, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 XX XX 2 | F Hours 1⁽²7⁽²7⁽²8)⁷1⁽²9⁴3 PA **Director** 199-32-6342 68 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 Yes 2 No MD Port Deposit Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 21904 United States 61 Foxfire Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 K Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Project Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Berkey William T. Knott, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 Foxfire Dr., Port Deposit, MD 21904 Lorraine Knott / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 10/09/2012 Calvert, MD 4 ☐ Donation 5 ☐ Other (Specify) Rosebank Cemetery 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK CARDIDGENIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ACIDOSIS ACTIC Sequentially list conditions, If any, leading to immediate cause. Enter Underlying CARDIONYOPATHY igned by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last DISEASE Physician/Medical VALVULAR HEART Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death.

Funeral Director: After this continued to 1. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

I Director: After this certificate has be in by the funeral director, page 2 s autopsy performed' death? 2 🗹 No Yes 2 Z No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident Investigation 6 Could not be

Division of Vital

7 - 7

completed filled in by 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

10-5-2012

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Revolution Street Havrede Grace MD 21078 601

D0069118

State Registrar

Medical

29a. Certifier

(Check

hin 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ E-tober :Slam 2015 Cecelia Ann Kramer Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Plato -CL Char Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Country 1 □ M 2 😾 F **Director** 214-42-4605 68 Yrs. Wash., 02/21/1944 DC Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director ms 23a or 28a-f s must be notified 1 Tes 2 X No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 10909 Poplarwood Ct. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. or i þ 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2X No Specify: 5-0036 Specify. 3 X Widowed 4 ☐ Divorced "natural", Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than "I Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Govt. Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland and Mental ပ Loren Chester Moore Gertrude Lee Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health tem 27 MD 20603 Jackie Russell/Daughter 4052 Chimney Swiff Ct., Waldorf, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Church Ce10/24/12 Forestville, MD Epiphany ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRaymond Funeral Svc., 21. Signature of Funeral Service Live P.A. M01517 Washington La Plata MDAve. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tranthat initiated events resulting in death) Last 48 OVERNER AMPY Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 | Yes 2 No 9 | Unknown by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 2 No this certificate 1 Yes Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No Certificate: To 1 Napatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural (Month, Day, Year) work? 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or in 3 Certifying Nurse Practitioner/To the best of my knowledge. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier rson w pleted cause of death (Item 29a

State Registrar

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		State Registrar	e of Maryland /		rtment of F tificate of L		and Me		giene Reg. No	20	12	35220
Physicia	n/	Decedent's Name (First, Middle, Last) Harold	Frederick L	IINSRI	IRV			2. Date of De Month Ctobe		y 201	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and Autumn Assisted Livin	I number)	ONBBO	4b. City, Town, or			Сторе	4c	. County o	f Death	12:12p. ^M
Funeral		5. Social Security Number 6, Sex	7. Age (In yrs. last b	oirthday)	Hagers If Under 1 Year Months Days		24 Hrs. 8 Min.	8. Date of Bir (Month, Da	th	Washi		ice (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		ge (1-4 or 5+)	(Give ki life. DC	ent's Usual Occup ind of work done o NOT use retired) hinist	during most	of working	7		ind of Bus		stry cturer
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12 shouluith and 27 is m		19a. Informant's Name/Relationship (Type, Print) Ralph Powell - P.O.A.	I		g Address (Street a							
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	e to (or as a consequence									
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(2 Z)		29b. Signature and title of certifier	2		29c. License	number	23			e signed (
4		30, Name and address of person who completed Dr. ICNAID WASELD	cause of death (Item 23a	() (Type, Pr	Court	Han	1015	toivr	1.17	np	217	40
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DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar				C	ertificat	e of E	Death		Reg. N	10.20	12	15221
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Funeral		5. Social Security No		. Sex 7	Age (In yrs. I	last birthday		r 1 Year Days	If Under 24 Hr		irth	Т	9. Birthp	place (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lice	ensee			22. Name an			Rest Ha				-
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after Direction by		4 L Homicide	determine		Injury - At ho , etc. (Specify		street, factory	, onice		City or To			r or Hurai	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bit.	Medical	29a. Certifier 1	Certifying Pi	hysician: To the bes	t of my know	ledge, deat	h occurred at	t the time	, date and place	and due to the	cause(s)	and manne	er as state	ed.
the Hu nin 24 the Fu nplete	Mec	only one) 3	☐ Certifying N	miner: On the basis urse Practitioner: T	of examination the best of r	n and/or inv my knowled	estigation, in i ge, death occi	my opinio urred at th	n, death occurred ne time, date and	at the time, date place, and due to	and place the caus	e, and due se(s) and ma	to the cau anner as s	ise(s) and manner stated. tated.
With Son Join		29b. Signature and t	title of certified				290	. License	number			ate signed		
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N-2		30. Name and addre	Homo	o completed cause	Pen i	- 1	(Guica	A	rene 1	4000	You	in	03	2012
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Leroy Lemon October 9:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Fox Chase Nursing Home Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 223-36-6462 1 🕱 M 2 🗆 F Yrs 80 May 11, 1932 Virginia ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20032 United States 58 Galveston Street SW death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or ð 1 Never Married 2 Married 3altimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Black. Specify Completed 3 XWidowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) College (1-4 or 5+) 12th Postal Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fred Joe Lemon Katie Lily King injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 1371 Hamilton Street NW Washington, DC 20011 Deborah M. Porter - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Data . 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenHill Cemetery 2012 Hot Springs, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician. Malignant Carcinoid Tumor of the Ileum disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria • Hospital or Attending Physician: The law requires that the death certificate be ¿24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial letely filled in by the funeral director, page 2 should be detached for use as the buring buring the funeral director. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 ☐ Yes 2 🎛 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗆 Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 D Yes 2 D No M Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funel completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Kouakhou, D63748

Registrar
DHMH 17 Rev 06-201

BOSM

State

201 East University Parkway

21218

Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou,
31. Date filed (Month, Day, Year)

OCT 1 8 2012

MD

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 12:49 p M Oct. Lancaster Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince George's Thomas More Medical Complex If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Country) 1 □ M 2 🖾 F Months Days Hours Min 62Yrs 578-68-5056 Director June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 X Yes 2 ☐ No Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1312 Adams Street NE 20018 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Black 1 ☐ Yes 2 ANO Specify. Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) uld be filed within 7. Mental Hygiene. other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked James Lancaster Esther V. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 si ment of Health a item 27 Angela Lancaster - Sister 620 Quintana Place NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0ct. 2<u>012</u> permit. Page 1 a
Department of H
Important: If ite 9 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9 John I Stewar M00560 4001 Benning Road NE Washington. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIORESPIRATORY disease or condition HUCLE Medical resulting in death) Examiner MEMOSLLeone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Resountentailure trach coller 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Cerebral Infanction 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page death? typeatourin 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) æ Hospital Other: 1 ☐ Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I (Month, Day, Year) 1 Natural 5 Pendina injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

400

Baltimore, Maryland 21215-0036

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

DeV

October 15

DHMH 17 Rev 1/2001

State Registrar SANDESP

31. Date filed (Month, Day,

Veirs

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2. Registrar's Signature

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1 Pay 20 Pm Robert Lipscomb 11:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fox Chase Nursing Home Silver Spring Montgomery If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 82 249-40-3220 Director 5/22/1930 South Carolina Usual Residence of Decedent daath with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 8how r than "natural, or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director DC None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Ninth Street N.W. 20012 USA Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 (≙) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. a filad within 72 hours aftar d ii Hyglana. other than "natural", or iten Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: Specify: ፩ Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) years Elementary/Secondary (0-12) 3 Counselor DC Government Pagas 1 end 2 should ba filad in ant of Haalth and Mantal Hygis int: If Itam 27 is marked other trsumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Hattie Lipscomb Cess Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6811 Ninth Street N.W. Washington, DC 20012 Flora Lipscomb/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Paga Dapartmant o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cremator \$\forall 0/18/2012 | Alexandria, VA 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician end d be deteched for use as the burial-transit Tha law raquires that the death cartificate be axecuted Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Pulmonary Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45☐ Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cartificate has autopsy performed? Yes 2 No 1 ☐ Yes of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4\(\frac{1}{2}\) Nursing Home 5 \(\text{Residence}\) Residence 6 \(\text{Other}\) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this neral Director: Aftar th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Division tha Hospital or Attanding 1 XNatural 5 Pending investigation aftar daath. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 10/16/2012 D52261 an 5JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Alan R. Segal, MD 31. Date filed (Month, Day, Year) Hugo/Circle Silver Spring, MD 20906 MD 1517 State Registrar

DHMH 17 Rev 1/2001

Priysician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

permit. Page 1 and 2 should be filed w Department of Health end Mental Hygi Important: If Item 27 Is marked othe any Injury or other traumatic event,

Physician/

Medical

10a. State

Director

Funeral

፩

Completed

Be

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

altimore,

Box 68760

Division of Vital Records, P.O.

Physician/Medical ģ Completed Be

မ

Certificate:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy performe 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

28a. Date of injury (Month, Day, Year) 28b. Time of 300 0 101112

28c. Injury at 1 ☐ Yes 2 X No

28d. Describe how injury occurred

down Hight of Stairs 74 Chipor Backeride Rd, Chincoteggue

0

SALISBUR

29d. Date signed (Month, Day, Year)

2012

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number **573705** HC0497 DIME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chris Snyder, DNE STREET ISHA PURI CARROLL EAST 00

0 31. Date filed (Month, Day, Year) State 16 2012

1 Natural
2 Accident

3 Suicide 4 Homicide

29a. Certifier (Check

5 Pending

Investigation

6 Could not be

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 3'.24 AM ewis Medical 7012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death niversitu Baltimore maryland Medical If Under 24 Hrs Hours Min. If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months (Month, Day, Year) Director 220-50-3640 1 XM 2 | F MAY 6, 1950 MARYLAND Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND CECIL ELKTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 116 CLINION STREET must 21921 UNITED STATES or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural". 3 Divorced Specify: Completed BLACK Year or Dates. 1968-70 traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ' should be filed within 7 hand Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) CONTRACTOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES W. LEWIS HAZEL SMITH t and 2 should be the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY J. LEWIS / WIFE 116 CLINTON STREET, ELKTON, MARYLAND 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place GARRISON FOREST VET. 4 Donation 5 Other (Specify) 10/19/12 OWINGS MILLS; MD 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE 21. Signature of Funeral Service Licenses MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burial-t attending physician Physician/Medical that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ jo in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. | by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician; The law autopsy perform page 2 Yes of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ,Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Division after death Director: / in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined filled Hospital within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature a nd title of certifier P 29d. Date signed (Month, Dav. Year) 8 ddress of per who completed cause of death (Item 23a) (Type, Print) VA ninwe altimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris Knotts Landis 2012 October 0 0250 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Augustine Herman Highway E1kton Cecil **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours (Month. Day Year) **Director** 211-26-8539 1 🗆 M 2 🗶 F 79 JAN 20, 1933 Pennsylvania item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Tes 2 X No Marvland E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 661 Augustine Herman Highway 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Pavroll Manager Chemical Hauling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ernest F. Knotts Rachel Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Debra K. Dickerson/Daughter 661 Augustine Herman Highway, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 19, 2012 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Unbrown Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy After this certificate ha funeral director, page performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a

To the Funeral C

completely filled

State Registrar

DHMH 17 Rev 06-2011

87, Elkun MD 21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year) 10.16.2012.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ McCollister 20T2 D'Arcy Edward 8:25 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Dorchester Chesapeake Woods Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye Dec 29, 9, Birthplace (State or Foreign 7, Age (In yrs. last birthday **Funeral** 1 ★ M 2 □ F Mary Land Yrs 217-36-1799 84 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** MD Cambridge Dorchester 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6145 Castle Haven Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) agriculture farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mabel Mever Thomas A. McCollister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis E. McCollister 6143 Castle Haven Road, Cambridge, MD son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Dorchester Mem. Park 10/18/12 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastake l'averecht Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Ceck only one) Be examiner? 1 🗌 Yes 2 4No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera iniurv Natural Accident 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 10-15.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN THANWY 503 BYRV CAMBRIDGE MD 21613 503 NOMAN THANWY 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Dhysisis	. /	1. Decedent's Name (First, Middle, La							2. Date of Dea Month		/ Year	3. Time of Death
	Physicia Medic	al .	E. E. Bern							October			4:00 P M
1	Examin	er	4a. Facility Name (if not institution, giv	e street and number)		4b. City, To			of Death 7 i 11e		4c.	County of Dea	gomery
ألمسيد	Euporal		Casey House 5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday	If Under 1	Year	If Under	24 Hrs.	8. Date of Birt		9. Bi	rthplace (State or Foreign
	Funeral Director			1 [] M 2 [X] F	V	Months	Days	Hours	Min.	(Month, Day			ountry)
	, M		Usual Residence of Decedent	8						March 3	1, 1	.929	Virginia 10d. Inside City Limits
	yland -f sho	Director	,		c. City, Town or I	ocauon.		• 1					1 ☑ Yes 2 ☐ No
	r 28a notifi	Öire	Maryland Montgo	mery		10f. Zip C		ilve	Spr	ing	10a Citi	izen of What C	
:	be filed within 72 hours after death with the Maryland setal Hyglene. Red other than "natural", or items 23a or 28a-f show keed other than "natural", or items 23a or 28a-f show to event, the Medical Evantiner must be notified at.		2202 Richland	Street		101. 219		910			•	nited S	
	ems :	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13	. Was Deceder			igin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am	erican Indian,
တ္	or it	by F	1 🛛 Never Married 2 🗆 Married	Armed Forces? 1 Yes 2 No If Yes, Give		1 ☐ Yes 2				Hican, etc.)		Black, Whi Specify:	_{ite, etc.} B1ack
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Maryland 21215-0036	of and 2 should be file of Health and Mental I fitem 27 is marked or other traumatic ever		19a. Informant's Name/Relationship							I Route Numbe			
	and 2 Health em 27 ther t		Berta Smith - Si 20a. Method of Disposition		1938 20b. Place of Dis	Bunker		TT K		NE Was		ton, Do	
nor	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	cemetery, c	ematory or oth	ner place	ī	Oct.	19,		-	i, Maryland
Baltimore,	Ft. Lincoln Cemetery 2012 Brentwo 21. Signature of Funeral Service Usensee 22. Name and Address of Facility Stewart Funeral F M00560 4001 Benning Road NE Washington,												
ä	any per		John T. Ste	war ₹ M005	560	4001 I	Benn	ing				gton, I	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the	e death. Do not e	nter the mode	of dying	g, such a	s cardiac o	or respiratory ar	rest,		Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):								
	LXammer	ē	Sequentially list conditions,	b. Due to (or as a co	presquence off:						_		
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876			IF FEMALE:										
× 6	ath certific attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live Birth 2 L 4 Pregnant at tin	Fetal death	Ectopic pr		;y			i	23d. Date of d Month	delivery Day Year
Division of Vital Records, P.O. Box 68	the a	by Physician/N	1 ☐ Yes 2 ঐ No 9 ☐ Unknown	g Unknown	ne or death	Other (spe	-Cily)						
O.	requires that the der been signed by the a should be detached	y P	Part II. Other significant conditions	contributing to death but r	not resulting in th	e underlying ca	ause giv	en in Par	t I.	23e. Did 1	tobacco u	use contribute	to the cause of death?
<u>s</u> ,	uires t n sign uld be	ed b								1 🗆	Yes 2	□ No 3 □	Probably 4 \(\bigsi \) Unknown
Š	w required to see 2 sho	Completed								24a. Was		prior to	autopsy findings available o completion of cause of
Rec	The la ate ha page	E								perfe 1 ☐ Yes	ormed?	death?	? ⁄es 2 □ No
<u>ta</u>	cian: entific ector.	B	25. Was case referred to medical examiner?	Hospital:			Otho			k only one)			
Ę	Physi this c ral dir	2	1 Yes 2 No	1 ☐ Inpatient	2 ER/Outpa		A Our	4 📙	Nursing Ho	ome 5 Resi			ecify) Hospice
0	Attending Physician: The law requires that the death certificate ardeath. **rdeath.** **r	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day, Ye			work	? Yes 2	⊒ No	Edd. Describe	nou inju	, 000000	
isio	Atter er dea ector: by the	Į	3 Suicide 6 Could no	t be 28e. Place of Injury		street, factory,	office			28f. Location (Rural Route Number,
<u>≤</u>	tal or irs afte al Dir led in			building, etc. (S									
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Exa	hysician: To the best of my miner: On the basis of exam	nination and/or in	estigation, in m	ny opinio	on, death	occurred a	t the time, date	and place	e, and due to th	e cause(s) and manner state
	To the I within 2 To the I comple	Ž	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practitioner: To the be	est of my knowled			ne time, o		ace, and due to		ate signed (Mo	
	F \$ F 0		1 Citch	e //			ī	03714	12		Oct	ober 1	5, 2012
	9-00		30. Name and address of person wh	o completed cause of de	(Item 23a) (Typ	e, Print)		· -					
				355 Piccard		Rockvil	1e,	Mary	1and	20850)		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's		British							
DU	AH 17 Rev 06-	_	991-95			<u></u>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3523 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 10-14-2012 DESOREE VERONICA MINER 19:52 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON PG SOUTHERN MARYLAND HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 577-76-1405 58 Director 1 □ M 2 🛣 F 03-14-1954 DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ed other than "naturai", or items 23e or 28e-f sho event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Directo 1 Yes 2 □ No DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 US 7202 DONNELL PLACE, #D3 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other treumetic event, the Mer Elementary/Secondary (0-12) 12TH College (1-4 or 5+) ACCOUNTANT PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဍ ERMA B. DORSEY ALFRED MINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KING MINER/SON 1575 TEMPLE AVE, MAYFIELD HEIGHTS, OH 44124 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
WASHINGTON NATIONAL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-22-2012 SUITLAND, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lic 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami physician and s the burial-transit Hospitai or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENSION 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 12 No After this certificete funeral director, pag 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ဂ္ 1 Compatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending Division 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Investigation 6 Could not be ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 85.00

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

NIZAM UD DIN, M.D. 7503 SURRATTS ROAD, CLINTON, MD 20735

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				epartment of Health and N Certificate of Death		jiene _{Reg. No.} 2 ()	12	35232
	Physicia	ın/	Decedent's Name (First, Middle, Last)		2. Date of Dear		Year	3. Time of Death
	Medic	al	Hazel McConico 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	10	4c. County	610	02:18 AM
	Examin	er	Prince Georges Hospital	Cheverly				orges
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 1 1 - 3 2 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Countr	ace (State or Foreign y)
	4-1200		Usual Residence of Decedent		03/16/	1949	Alak	ama
	tryland a-f sho ied at	Director	10a. State 10b. County 10c. City, Town or Washing				10	d. Inside City Limits 1 🕅 Yes 2 🗌 No
	the Ma or 28a e notii	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Count	
	h with ns 23a nust b	Funeral	21 Kennedy Street NW	20011		USA		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married I Sives 2 No If Yes, 2 No	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 XNo Specify: 	ecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, et $^{\circ}$ Blac	c.
2-00	hours natura dical E	olete	15. Decedent's Education 16a. De	ecedent's Usual Occupation ive kind of work done during most of work	ina	16b. Kind of E		
Baltimore, Maryland 21215-0036	ithin 72 ene. • than ' the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	the kind of work doine during most of work o. DO NOT use retired) Clorist	·	Privat	te	
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<u>ti</u>	iit. Pag artment ortant: injury o		4 □ Danation 5 □ Other (Specify) Palme: 21. Signature of Funeral Service Licensee	r Cemetery 10/2 22. Name and Address of Facility St	0/12-	Furma	n, Al	abama ₁₁
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ل	'hysician/ Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (a as a consequence of): Sequentially list conditions, if any, leading to immediate		or respiratory arre	est,		Approximate Interval Between Onset and Death
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 1 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 1 ☐ Live Birth 2 ☐ Fetal	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			ate of deliver	y Day Year
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ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 V Insertion: 2 FB/Outpot	26. Place of Death (Check				
of \	ng Phy ter this neral d	te: To	27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending 2 Inpatient 2 ER/Outpa 28a. Date of injury (Month, Day, Year) 28b. Timinjur	e of 28c. Injury at	ome 5 🗌 Reside 28d. Describe ho			
ion	ttendir death. tor: Af / the fu	Certificate:	Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	200 1 10 (01		D//	D- A- Al
	al or A s after al Direct		4 Homicide determined building, etc. (Specify)	street, factory, diffice	28f. Location (St. City or Town		er or nurai r	noute Number,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Medical Examiner: On the basis of examination and/or in 3 Certifying Nurse Practitioner: To the best of my knowled	vestigation, in my opinion, death occurred a	t the time, date an	d place, and du	e to the caus	se(s) and manner stated.
	Vith Vith Con		29b. Signature and title of certifier BY 32h	29c. License number	2	9d. Date signe	d (Month, D	ay, Year)
	2 J.M		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	<u> </u>	1019	119	
			Karen Brooks 3001 Hospil	e, Print) SR Cheverly	mo	207	85	
	Stat Registra		31. Date filed (Month, Day Year) 2012 2. Registrar's Signature	arks				

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green of	Examin		4a. Facility Name (if not institution, gi VILLAGE AT				4b. City	, Town, or OCKV	Location o	f Death			County of Dea MONTGO	MERY
	Funeral Director		5. Social Security Number 585-10-8897 Usual Residence of Decedent	Sex 1 M 2 □ F	7. Age (In yrs. I	99 Yrs.	If Und Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da JUNE	y Year)	1913-I	thplace (State or Foreign unity) LLINOIS
	Aaryland Ba-f show tified at	rector	10a. State 10b. County	GOMERY	10c. Cit	ty, Town or Lo	cation CKV	ILLE						10d. Inside City Limits 1 1 Yes 2 □ No
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9036	o filed within 72 hours after death with the Maryland tal Pyglene. Ital Pyglene. Ital Pyglene. Ital other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 🔯 No				spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: WH	
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Baltimore,	permit. Page 1 el Department of H Important: If itel any Injury or ott	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe		10/	· -•	ALE	ocation - City or	A, VA.						
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ta	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?	The series					ace of Deat	h (Checi	k only one)			
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	the Hospinin 24 ho	Medical	only one) 3 L Certifying N	miner: On the bas	is of examination	on and/or inves	tigation, i	n my opinio	on, death oc	curred a	t the time, date	and plac	e, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier	m_			29	D 0	number	58			ate signed (Moni	h, Day, Year) 5 201 L
	105m		30. Name and address of person wh	o completed caus	-		Print)	IVF	R	OCK			MD 208	
	Sta Registra		31. Date filed (Month, Day, Cear)		egistrar's Signa				•	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret E. Mayhew 12:45 A M Medical Oct. 15. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Bradford Oaks Nursing Home Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Days Hours 577 42 5257 Director 1 □ M 2 🗓 F 87 Nov 13, 1924 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 🗌 Yes 2 🗓 No Forestville Maryland Prince George's 0 10e. Street and Number 10g. Citizen of What Country? 23a United States 20747 3013 Tracy Lane Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. "natural", or iter Armed Forces? Completed by X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes. Give 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 27 is marked other than "natural raumatic event, the Medical 15. Decedent's Education . Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Hame Homemaker 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Moore Francis Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Gray (niece) 3013 Tracy Lane, Forestville, MD 20747 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Oct 18, 2012 | Clinton, MD Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): burial-tra resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnate 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \nearrow No 3 \square Probably 4 \square Unknown this certificate has been signal director, page 2 should? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 2 🗌 No 1 Tyes Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 🗀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred l or Attending F after death. 1 Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At Accident Investigation М 1 Yes 2 No the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D35206 OCTUBEN 15, ZOIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Wingh Rond Fort WASKigh JANNER MM 31. Date filed (Mont) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:410 October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lashington Muses Hagerstown Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Bir hplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 20.42.7202 Director Dec. 29, 1944 67 Maryland 28a-f show 10d. Inside City Limits artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S. A. 21740 353 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Whit 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Nechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) J. Miller- WI Hager MD 21740)onna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Smithsburg, M.D. Smithsburg Gematory 10-16-2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Ficility Douglas A. Fiery Functal Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between nset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic Chal LENS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transit and Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 16 D58195 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1138 Opal Bu. Hagerstown 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Ellen Mills October Dorothy / (M Medical 4b. City, Town, or Location of Death Hagerstown 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Meritus Medical Center Washington Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Mir 217-42-7507 72 1 □ M 2**X**□ F **Director** 5-25-1940 MD Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d Inside City Limits 10a State Director MD Washington Big Pool 1 Yes 2 X No 10f. Zip Code 21711 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a o 10926 Big Pool Road Funeral U.S.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 Yes 2 No Specify Specify. Completed 3℃ Widowed 4 □ Divorced er than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Food service vendor Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hyginal Important: If item 27 is marked other than any injury or other traumatic event, the Monee. food preparation emp. 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Russell Paul Mills Virgie Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10926 Big Pool Rd. Big Pool, MD 21711 Dianne Mills daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Big Pool, MD Parkhead Cemetery 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service License 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc MOIYIY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Apnea Medical o (or as a consequence of) Examiner 10 year Renal stage Disease Sequentially list conditions Jer if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physiciar Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death Month Day 9 Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes 1 Tyes page 2 should Pulmonary Chronic Obstructive Were autopsy findings available prior to completion of cause of 24a. Was an DISPASO has autopsy this certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes မြ 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? Natural 5 Pending s after death. 2 Accident M Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State within 24 hours a

To the Funeral D Medical 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0066288 10-15-2012 MD

MD

Registrar's Signature

3Burkit

Drive

Williamsport MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crussiah

lania

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31. Date filed (Month

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	Physicia Medic	al	Ruth	B. N	nccullou	gh					Month /		ay DN YA	3. Time of Death 2:00 PM
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Т	Funeral		5. Social Security Nu 222- 6- "	72111	<i>y</i> °	e (In yrs. last b	irthday)	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Birt (Month, Da)	h y, Year)	9. Bir Co	thplace (State or Foreign untry)
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show with jujury or other treumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Num	camol	re Road	<u>L</u>		10f. Zip Code	t6_			Un.	itizen of What Co	itates
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	200		23a. Part 1. Enter the shock, or hear Immediate Dause	rt failure. List only	nplications that cause one cause on each lin	d the death. Do e.				is cardiac o	r respiratory ar	rest,	_	Approximate Interval Between Onset and Death
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68760	rtificat ling ph e as th	Μe	IF FEMALE:		23c. If yes, outcome	of programmy	_							
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	the de sy the ached	hysi	1 Yes 2 D 9 Unknown		9 🗌 Unknown									
P.0	s thet gned k	Completed by Physician/Medic	Part II. Other signif	icant conditions	contributing to death I	out not resultin	ig in the υ	nderlying cause	given in Par	rt I.	100	1111		o the cause of death?
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Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificate be within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Medical Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not determined	be 28e. Place of Inj	ury - At home,	farm, str		Yes 2					ural Route Number,
Divi	itel or urs efterel Dire	a Ce			building, et	c. (Specify)					City or Tov			
	e Hosp 24 hor e Fune letely f	ledic	(Check 2	☐ Medical Exar	ysician: To the best o niner: On the basis of ourse Practitioner: To the	examination and	d/or inves	tigation, in my or	inion, death	occurred at	the time, date a	and plac	ce, and due to the	cause(s) and manner stated.
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	20		30-Name and addre	UNEUE	completed cause of	leath (Item 23a	a)(TypHe,F	Print)	44	5 De Hani	pense	14	1D 214	01
	Sta Registr		31. Date filed (Mont	h, Day, Year)	2012 32. Registr	ar's Signature	Ø. 1	backed			1	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edward Russell Malone, October 2012 $10:29 \text{ AM}^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Union Hospital of Cecil County Cecil If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Min. 1 XM 2 🗆 F Vrs **Director** 232-70-0195 68 West Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 E1kton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1472 Elk Forrest Road 21921 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Hamman injury or other transmits. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Automotive Assembly Elementary/Seconday (0-12) College (1-4 or 5+) Millwright Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edward Russell Malone, Sr. Mary Ruth Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leeanne Malone / Spouse 1472 Elk Forrest Road, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 10 1 Burial 2 Tremation 3 Removal from State 4 Donation Other (Specify) 2012 Mayerdale Crematory Newark, Delaware Signature, of Canadal Service Livens 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARNAL INFARCTION ACUTE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions. Due to (or as a consequence of): e attending physician and ed for use as the burial-transit if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
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Hospital or Attending Physician: The law requires Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

State Registrar

10

Medical

29a. Certifier

NATHAN

31. Date filed (Month,

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HAMADEH

DHMH 17 Rev 7/2009

BOW STREET, ELKTON, MD 2192

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

63486

29d. Date signed (Month, Day, Year)

OCTOBER, 6,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35239 Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 5^{Day} 2012^{ear} Johnsie C. Madron 5:12p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Calvert Manor Healthcare Center Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days Hours 93 7/13/1919 Director 244-14-3949 NC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1881 Telegraph Rd. 21911 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 3 Widowed 4 □ Divorced If Yes, Give Specify White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed Iment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Graydon Campbell Emma Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Shires/ daughter 46 Foxfire Dr. Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ö Important; injury 4 Donation 5 Other (Specify) West Nottingham Cem. 10/10/12 Colora, MD of Funeral Service Licensee Signatur R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 Part 1. In ter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗆 No Yes 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTIN

101 COLONIAL

29c. License number

29d. Date signed (Month, Day, Year) 05

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar				C	erunce	ne or	Death					Reg. No	0.		
Physic dical Exam		1. Decedent's Nam Michae	ne (First, Midd e1 Lynr		rtin								Date of De Month October		, Year		3. Time of Death 0019 hrs
		4a. Facility Name (9714 Nation	•	on, give s	street and nu	ımber)		4	b. City, To Big Po		ocation of	Death			^{4c.} County o Washing		
Funeral		5. Social Security I	Number	6. Sex		7. Age (In yr	s. last birth	nday)	If Under	1 Year	If Under	24Hrs.	8. Date of E	Birth (MN	M/DD/YYYY)	9. Bir	thplace (State or
Director		213-76-32	293	1 X N	1 2 F		48	Yrs.	Months	Days	Hours	Min.	07/12	/196	64	Foreig Co	in untry) MD
-		Usual Residence	of Decedent														
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Maryl 28a-1 d at 9	Director	10e. Street and Nu							10f. Zip 0						itizen of Wha	at Cour	ntry?
h with the Maryland ems 23a nr 28a-f show be notified at once.		9714 Na	ational	. Pil	ke					217	711			US	A		
th wit	Funeral	11. Marital Status 1 X Never Marri	ied 2 M		12. Was Dec Armed F	cedent Ever in orces?	ı U.S.		s Decedentes, specify				cify Yes or Nican, etc.)	lo-	14. Race - White		can Indian, Black,
or dear	큔				1 Yes Yes, Give Yes	2 X No	·		Yes 2 X	7 No.					Specify:	Whi	to
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21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygiene. marked wher than "matural", or items 23a nr 28a-f she c event, the Medical Examiner must be notified at once	8	McKinle				.n							salie				
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Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5				Pa	arkhe		emete		f Cariba				g Poo		
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or nither traumat	18	21 Signature of Fu	Ineral Service	0		_ MOO2	260		ame and A		_				in St		t 750 – 0368
Physician	_	23a. Part I. Enter th	he disease, or	complica	ations that c			t enter th	e mode of	dying, su	uch as car	diac or n	espiratory a	rrest, sh	hock, or hea	∠⊥. rt	Approximate Interval
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th cert	icia	past 12 months			4 Pregr	ant at time of			ner (Specif	y)							
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of Vital Records, P.O. og Physician: The law requires that the Affect this certificate has been signed by meral director, page 2 should be detach meral director, page 2 should be detach	by F	Part II. Other sign	ificant condi	ions co	ontributing to	o death but no	ot resulting	in the ur	nderlying c	ause giv	en in Part	1.	1 Ye	_			the cause of death? ably 4 Unknown
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Div ital or its after ral Di	Certification:	3 ✓ Suicide 4 Homicide		d not be rmined	(Specify)	Out side	of back	yard				97	or Town, '14 Nation	State) al Pike	, Big Pool,	MD	
Division of Vital I To the Bospital or Attending Physician: within 24 hours after death. The Funcral Director: After this certifi completely filled in by the funeral director,		29a. Certifier 1	Certifying P	nysician	: To the bes	st of my knowl	edge, dea	th occurr	ed at the ti	me, date	and place	e, and du	ue to the cau	ıse(s) a	ind manner a	as state	ed.
Fo the vithin Fn the	Medical	one) 2 🗸	Medical Exa		n the basis on the manner s	of examination tated.	n and/or in	vestigati	on, in my c	pinion, c	death occu	erred at ti	he time, date	e and p	lace, and du	e to the	e cause(s)
C > F 2	ž	29b. Signature and	title of certifie	er .	~					License i							oth, Day, Year)
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HIII		30. Name and addr				se of death (It miner 90		ltimor	o Stroot	Raltin	noro M	D 212	23				
· ·	toto	Ling Li, MD 31. Date filed (Mon		iii iviec		egistrar's Sign				Dailin	nore, M	J 2124					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30, per dvr. 9933 11-2-12 sm
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2012 Physician/ 7:05 AM ^M October Robert J. Mitchell Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Marys Charlotte Hall Veteran's Hall Charlotte Hall 8. Date of Birth (Month, Day, Ye Sept. 8, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Year) 1921 Pennsylvania 1 🔀 M 2 🗆 F Sept. Director 199-09-8123 91 Usual Residence of Decedent and Mental Hyglene.

i and Mental Hyglene.

i se marked other than "natural", or items 23a or 28a-f show

i se marked other than "fatural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No MD Mechanicsville Saint Marys 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral USA 20659 30165 Huntt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 ▼ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nina Williams Edward John Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30165 Huntt Road Mechanicsville MD 20659 Barbara A. Holmberg-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery Oct.27,2012 Louisa, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 200 Fredericksburg Ave. Ell Woodward Funeral Home Louisa, VA 23093 M00945 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ RONTE disease or condition Lerry Medical resulting in death) Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day n signed by the a Ild be detached f 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? LEUKOCYtosis 24a Was an autopsy performed certificate has funeral director, page ANEMIA 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ after death. Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signat 29d. Date signed (Month, Day, Year) 40037229 mD OCT. 25, 2012

Registrar

State

fare

Rd. Charlotte Hall, MD, 20622

29449 Charlotte Hall

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Cafferty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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edical Examin	er	Troy Remar Neal, Jr.							Month October 1				1534 hrs
	ı	4a. Facility Name (if not institution, give street and Prince George's General Hospital	number)		lb. City, To Cheve		ocation of	Death			County of I		S
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à	-	Usual Residence of Decedent 10a, State 10b. County	Ing. City	Town or Locati	on				•			1	10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f about jury or other traumatic evect, the Medical Examiner must be sotified at socc.	2	9a. Informant's Name/Relationship (Type, Print) Tammy Talley/Mother							ral Route Nur Le Hill				Zip Code)
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b. Box 6876 the death certificat the attending phy ched for use as the	2	past 12 months?	gnant at time of de	oth _	er (Specif	-		- 					,
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physiciae: The law requires that the death certificate within 24 hours after death. To the Purceral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tending of the certification: To Be Completely Hospitalization:	3	one) 2 Medical Examiner: On the bas	is of examination a	-									
To with	ᆰ	and manne	r stated.		29c.	License	number			29d. Da	ate signed	(Mont	h, Day, Year)
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DHMH 17 Rev 1/2001 OCME 2006 WALL B ALLE

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Claire Nutzman 12:45pM act 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fahrney-Keedy Home and Village Boonsboro Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-32-6923 Hours (Month, Day, Ye 94 Yrs Director 1 M 2 X May 11,1918 Iowa or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Funeral Director WV Jefferson Harpers Ferry 1 Yes 2 X No 10e. Street and Number 393 Ceasar Road 10f. Zip Code 10g. Citizen of What Country? 25425 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 X Widowed 4 □ Divorced of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Ray Radliff ပ Orpha Witlow Page 1 and 2 should be fi ment of Health and Menta ant: If item 27 is marked 9a. Informant's Name/Relationship (Type, Print)
Robert L. Nutzman/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13545 Piney Run Lane, Purcellville, VA 20132 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Edge Hill Cemetery o = 0 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Oct. 19,2012 Charles Town, WV 4 Donation 5 Other (Specify) Name and Address of Facility
Melvin T. Strider Co.Inc.
310 South Fairfax Blvd., Ranson, WV 21 Signature of Funeral Service Licenses 25428 Approximate Interval Between 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, by heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ewen Medical evaccular Offers Examiner her-tencik Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 25. Was case referred to medica 26. Place of Death (Check only one)

or Attending Physician: The law requires that the death certificate be Division of Vital within 24 hours after death.

To the Funeral Director: After

Certificate: To

examiner? 2 No 1 🗌 Yes Manner of Death

29b. Signature and title of certifie

Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide

determined

Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of iniury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work?
1 Yes 2 No

2723

28f. Location (Street and Number or Rural Route Number, City or Town, State,

10-13-2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

death (Item 23a) (Type, Print) address of person who cor

Khalid Waseem, M.D., 1126 Opal Court, Hagerstown, MD 21740

State Registrar

filled in by

Medical

29a. Certifier

31. Date filed (Mont.

Hospital

JN-6

				Pleas	e Type or Pr							-		•	∍.
1			For State		State of N	/larylan					and M	lental Hy	/gien	e 2012	35244
0			Registrar 1. Decedent's Name	e (First Middle 1	ast)		Cer	tificate	OIL	peatn		2, Date of De	Reg. N	10- U 4	
3	Physicia Medic		Catherine	Victor	ria Olive	r						OC to b	Г)ay 201	3. Time of Death 2 3:03 PM
	Examin	er	0	Α Λ	ve street and number)	nte	_	4b. City,	Town, or	Location	of Death	,	4	c. County of De	ath 105
5	Funeral		5. Social Security No		.,,	1 1 1	ast birthday)	If Under		If Under		8. Date of Bir	rth	9. E	Birthplace (State or Foreign
\leq	Director		577-50-36		1 □ M 2 X F	76	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year) 26,	1936	Country) MD
=	nd how at	ř	Usual Residence of 10a. State	of Decedent 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
5	farylar Ba-f s tified	ecto	MD	Charle	es	We	1come								1 Yes 2 XNo
3	a or 2 be no	ا اقا	10e. Street and Nun	nber				10f. Zip					10g. (Citizen of What	Country?
MYGST	th with ms 23 must	Funeral Director	6760 Port	Tobacco		Francia III	2 40 3		693		i=l=2 (C==	-if. Var. ov No.		USA	
S	er dea or iter niner	by Fu	 Marital Status Never Marri 	ied 2 🗆 Married	12. Was Decedent Armed Forces 1 Yes 2	?_	1	Yes, spec	fy Cubai	n, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)	•	14. Race - An Black, Wh	nerican Indian, nite, etc.
7 C 215-0036	ırs aftı ural", I Exar	ted b	3 🔀 Widowed	4 Divorced	If Yes, Give Year or Dates.			☐ Yes	2 🔁 No	Specify:				Specify:	White
5-5	72 hou "natu edica	Completed	(Spe	15. Decedent's cify only highest (Education grade completed)		16a. Deced (Give	kind of wor	k done d	ation <i>uring m</i> os	t of worki	ng	16b.	Kind of Busines	ss/Industry
12.5	ithin ithin ithen.	Con	Elementary/Seco	ondary (0-12)	College (1-4 or	5+)	_	o <i>NOTu</i> se maste					US	Posta1	Service
DB.	filed valued that the state of	Be	17. Father's Name ()							(First, Middle		n Surname)	
Stan	uld be Ment narker	우	Carroll W							Mar	y Luc	cille R	ice		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Important: I fire Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Catherine		(Type, Print) /Daughter		ŀ	-				1d. 206		or Town, State, 2	Zip Code)
Ore,	of Hee fitem rothe		20a. Method of Disp		Removal from Stat	20b. F	Place of Disno	sition (Nam	e of			ate	20c.	Location - City	
(ef Baltimore	Page tment tant: I		4 Donation	5 Other (Spec	cify)	St.	ignat				10/15			11top,	
Bal	permit Depar Impor any in once.		21. Signature of Fur	neral Service Lice	nsee 5%	м0094	5					nart-Ec a, Md.			al Home, PA
-			23a. Part 1. Enter t	he disease, or cor	mplications that cause	ed the deat								40	Approximate
	hysician/		Immediate Cause (Final	one cause on each li										Interval Between Onset and Death
1	Medical Examiner		disease or conditio resulting in death)		a. Due to (or as	p 5	uence of):								
	LAGIIIIICI	er	Sequentially list con	nditions,	b. Due to (or as	a consequ	ience of).								
	rted d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	injury 📉	Due to (or a	s a consequ	derice oij.								
	execu an and irial-tra	al Ex	that initiated events resulting in death) l		Due to (or as	s a consequ	uence of):								
09	ath certificate be executed attending physician and for use as the burial-transit	dica		•	d										
09289	entifica iding p	/Me	IF FEMALE: 23b. Was decedent	prognant	23c. If yes, outcom	e of pregna	ıncy							23d. Date of o	deliven
Вох	eath c atten d for u	iciar	in the past 12 r	months?	1 ☐ Live Birth 4 ☐ Pregnant	2 Feta at time of o	al death 3	Ectopic p Other (sp		у				Month	Day Year
P.O. E	t the d by the stache	Physician/Medic	9 🗌 Unknown		9 Unknowr							T			
G.	requires that the des been signed by the a should be detached	by	Part II. Other signif	icant conditions	contributing to death	but not res	suiting in the u	naeriying d	ause giv	en in Part	l.				to the cause of death? Probably 4 Unknown
ords	requir been s	letec										24a. Was			autopsy findings available
ecc	e has age 2	Completed										auto perf	psy ormed?	prior to death	o completion of cause of ?
<u> </u>	an: The	Be C	25. Was case referre	ed to medical					26. Pla	ace of Dea	ath (Check	1 Ves	2	No] 1 ⊔ Y	/es 2 □ No
ĘĘ.	hysici nis cer il direc	To E	examiner?	No	Hospital: Inpa	tient 2 🗆	ER/Outpatier	t 3 🗆 DC	Othe	er: 4 🗌 Nu	ursing Ho	me 5 Resi	idence	6 Other (Spe	ecify)
J of	ling P	ate:	 Manner of Death Natural 	5 Pending	28a. Date of in (Month, D	jury a <i>y, Year)</i>	28b. Time of injury		Bc. Injury work		- 1	28d. Describe	how inju	ury occurred	
Division of Vital Records,	Attend r deatl cctor: by the	Certificate;	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigati 6 Could not determine	be 28e. Place of Ir	jury - At ho	ome, farm, stre	M eet, factory		res Z L	_				Rural Route Number,
Divi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. within 24 hours affect death. within 24 hours affect death. completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.			1	building, e	tc. (Specify	′)					City or To			
:	Hospi 24 hou Funer letely fi	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of urse Practitioner: To t	examination	n and/or invest	igation, in r	ny opinio	n, death o	ccurred at	the time, date	and plac	ce, and due to th	e cause(s) and manner stated.
:	To the within To the compl	2	29b. Signature and		Confedences: 101	TIE DESCOLL	ny knowledge,			number	ice and pia	oo, and due to		ate signed (Mor	
	in		1 the	mes	Harry				200	539	919		10	/12/1	2
	00-10		30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Type, F	rint)		- 11	110	11	00	16.1	mn 201 U/
	Stat	e	31. Date filed (Month	h, Day, Year)	0040 32. Pegisi	rar's Signat	ture ture	inia	ال		11+	-1 4	UP	WIU, I	111 2007 Q
A.	Registra			OCT 15	2012 /	un	A. 1	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, c, perfit, G933, IT/8/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Floyd Partridge Jr. 2. Date of Death Physician/ Oct. 16, 2012 0456 A M Medical 4a. Eacility Name (if not institution, give street and number)
Washington Adventist Hospital **Examiner** 4b City, Town, or Location of Death Takoma Park 4c. County of Death
Montgomery 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 579 – 38 – 1120 **Funeral** Months Davs Min. 1¥ M 2 □ F Director 81 Yrs. Oct. 23, 1930 West Virginia or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Directo D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 20005 10g. Citizen of What Country? Funeral 1425 N St. N.W. Apt 410 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1

✓ Yes 2

No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced r Yes, Give Year or Dates.1 9 5 1 – 5 3 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene, a marked other than "r Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Self Employed Truck Driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Floyd Partridge Sr. Estell Holston permit, Page 1 and 2 sho.
Department of Health and Important: If Item 27 is may any injury or other trees. 19a. Informant's Name/Relationship (Type, Print) Dayshter Margaret Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 4th St. NW Washington, D.C.20001 20a. Method of Disposition 20b. Place of Disposition (Name of G1enwood uplace) 20c. Location - City or Town, State Washington, DC unknown Nov. ungnowr 1 Burial 2 Cremation 3 Removal from State unknown 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 201 CC031 Wash., 21. Signature of Funeral Service Licenses 22. Name and Address of Facility D.C.20001 alm Robinson Funeral Home 1313 6th St.NW Karlomin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final em o Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Canler ung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit cophaseal that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ate has been signed by the a page 2 should be detached (9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 K No 25. Was case referred to medical examiner?
1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation М 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52326 16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Lightfoot MD Washington Adventist Hospital Takoma Park, 25m Ave. Md20912 2. Registrar's Signature State Registrar

Paulne Piraino Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 35246 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7.408M uline torsyth Pirainc 20/4 10 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington HOPIS Trun NUISING lan If Under Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 - M 200 F Months Days Hours 214-16-1456 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic axes. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A. 1183 21742 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No lf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EWIS torsyth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Clear Spring, MD 21722 14033 Dry Run Rd. Meagher-Son 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition-1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2012 Smithsburg, MD Smithsburg Crematory 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstoin, MD 21742 Callen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician**) lac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗖 🗘 o 3 🗆 Probabiy 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar

31. Date filed (Month) State

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ical

29b. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:00 AM 2CTUBER POPS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 50 5251 SYSTEM POIN HEALTHCARE MARYLAND Z If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5€X 1 1 M 2 □ F n. 7⁹, 1958 Months 54 Days Hours Min. 220-66-0442 Mary land Jan. Director 3000 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil Maryland 1 Yes 2 No Colora 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o PHYSICIANS Funeral 831 Harrisville Road U.S.A. 21917 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. Yes 2 No δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify. 1 and 2 should e filed was.

A of Health and Mental Hygier.

If flem 27 sm mar ed other than "natural".

"If flem 27 sm martic event, the Medical Ex 3 Divorced 4 Divorced Year or Dates. 1976 - 78 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Airman First Class U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne C. Corcoran Edgar M. Pope AME FLOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) (sister) Anne Eve 6 Stoddard Court, Sparks, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Trinity ry Epistopai Church Cemetery 1 Durial 2 Cremation 3 Removal from State 10/09/12 4 ☐ Donation 5 ☐ Other (Specify) Glen Arm, Maryland 21. Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SOPHAGEA NKNOWN disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Pregnant at time of death Month Day Year detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of prominering and/or investigation, in my existing death occurred at the time, date and place, and due to the cause 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number PA Gode 29b. Siana 5 MDO726921 1 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCK, M. D. VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, M.D. DEBORAH State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Earlie Bass Powell, Jr 25 <u>October</u> 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9251 Kris Dr. White Plains Charles If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 223-38-7023 **Director** 1 🛛 M 2 🗆 F 78 Virginia 10/04/1934 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No MD Charles White Plains 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9251 Kris Dr. 20695 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Dates 1952 Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry المالية. المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Govt. Printing Ofc Camera Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! is marked o ည Earlie Bass Powell, Sr. traumatic Agnes Virginia Burton Department of Health an Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda J. Powell/Spouse 9251 Kris Dr., White Plains, MD 20695 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/12 Alexandria, VA Crematory 22. Name and Address of Facility Raymond Funeral Svc., 21. Signs the of Funeral Service Inc M01517 5635 Washington Ave., La Plata, 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between WC Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** writially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-transit resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death
Unknown Yes 2 No should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 \(\subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be after death Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Month, Day,

20b Signatu

e and title of certifier

Year,

se of death (Item 23a) (Type

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Lorraine Faith Parlow 2, Date of Death 3. Time of Death Physician/ ₩[™]0 / 13 / 2 12 12:55 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) 75 Yrs. 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Newry)York Director 106-28-1322 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director MD Harford Havre de Grace 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 248 Smarty Jones Terrace 21078 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Business_Manager Business Be 18. Mother's Name (First, Middle, Maiden Surname) Ruth Shapiro 17. Father's Name (First, Middle, Last) and Mental F Charles Locke permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21\,0\,78\,$ 248 Smarty Jones Terr, Havre de Grace, MD 19a. Informant's Name/Relationship (Type, Print) Adam Parlow (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 2Weston Chester, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA COMPLET LIST & Other place) 10/15/2012 Pennsylvania 21. Signature of Frind al Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. Washington St. Havre de Grace, S. 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between HOVRS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MONTH sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burian Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No မ 1 Yes 1 Phopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Deatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oupperchesapoake Drive Bel Air MD 21014 State Registrar

DHMH 17 Rev 7/2009

Par 10W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:45P^M 10 Kennith Dean Quesenberry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19 McCummins Lane Rising Sun Ceci1 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 226-44-3146 1 🖾 M 2 🗆 F 79 11/02/1932 Item 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 72 hours after death with the Maryland Director 1 Yes 2 XNo Ceci1 Rising Sun 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21911 19 McCummins Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in the end Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Industrial Mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hosie Lee Quesenberry Pearlie Mae Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 693 Southwood Road, Hockessin, DE 19707 Kennith Quesenberry/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Depertment of H Important: If Ite any Injury or ott 10/1272012 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Foard Funeral Home, P.A. Rising Sun 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service License 111 S. Queen St., Rising Sun, MD 21911 complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Enter the disea Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): After this certificate has been signed by the attending physicien and funerel director, page 2 should be detached for use as the burlel-transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funerel director, page 2 should be detached for use as the burlel-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (C only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ess of person who completed cause of death (Item 73a) (Type, Print)

State

Registrar

31. Date filed (Month, Day

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	State	partment of Health and Mental Hyglene ertificate of Death Reg. No. 2 1 1 2 2	5251
	100		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Ti	ime of Death
	Physicia Medic		Geraldine Quinn	October 9, 2012 6	:00 a M
	Examin	-	4a. Facility Name (if not institution, give street and number) 67 North Main Street	4b. City, Town, or Location of Death Port Deposit 4c. County of Death Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		State or Foreign
	Director		274 – 32 – 6381 Usual Residence of Decedent	Sept.19,1935 North C	
	and show	ō	10a. State 10b. County 10c. City, Town		side City Limits
	Maryi 28a-f otifie	irec	Maryland Cecil		X Yes 2 ☐ No
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. At Hygiene. Ad other then "natural", or items 23e or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 67 North Main Street	10f. Zip Code 10g. Citizen of What Country? U.S.A.	
	death items ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind Black, White, etc.	ian,
039	rs after rral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒ No Specify: Specify: White	
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272	vithin jiene.		Elementary/Secondary (0-12) Seven Years College (1-4 or 5+)	stodial Engineer Baltimore Coun	ty, MD
2	filed y tal Hyg d other event,	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
<u> </u>	0 5 2 0	٦	unknown 19a. Informant's Name/Relationship (Type, Print) 19b	illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, ⊠a	nd 2 should I salth and Me n 27 is marl		Solona Quinn (daughter) 67	lorth Main Street, Port Deposit, Maryland	
Baltimore, Maryland 21215-0036	Page 1 and 2 nent of Healt ant: If item 2 ary or other		1 D Burial 2 N Cremation 3 D Removal from State cemeter	position (Name of ematory or other place) ris & Co.,Inc. 10/12/12 20c. Location - City or Town, Si West Chester, Pennsylva	nia
Balti	permit, Page 1 a Department of I Important: If its any injury or of		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A	
			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.		roximate val Between
_ F	nysician/		Immediate Cause (Final disease or condition	N Cl R	et and Death
	Medical Examiner		Due to (or as consequence of		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	A transit	Examiner	Cause (Disease or injury that initiated events c.		
0	ficate be executed g physician and as the burial-transit	edical E	resulting in death) Last Due to (or as a consequence of d.		
8760	tificate ng phy s as the	Med	IF FEMALE:		
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day	Year
Ö.	nat the ed by ti detach	Phy	Part II. Other significant conditions contributing to death but not resulting	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cau	ise of death?
S,	uires ti n signo uld be	ed by		1 ☐ Yes 2 ☐ No 3 ☐ Probably	Unknown
Sor	aw req as bee 2 shor	Completed		24a. Was an autopsy fir prior to completi	ndings available ion of cause of
æ	sician: The law certificate has l lirector, page 2 s	Con		perfermed? death? 1 Yes 2 No 1 Yes 2	No
ita	ysician: lis certific director	Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpartient 2 FB/0	26. Place of Death (Check only one) Other:	
₹	ding Phys h. After this funeral d	15	27. Manner of Death 28a. Date of injury 28b.	e of 28c. Injury at 28d. Describe how injury occurred	
o o	ending sath. or: Afte the fun	ficat	2 Accident Investigation	y work? 1 ☐ Yes 2 ☐ No	
Division of Vital Records, P.O.	il or Attend after death Director: A d in by the I	Certificate	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)	e Number,
_	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in	Medical	(Check 2 Medical Examiner: On the basis of examination and/	th occurred at the time, date and place, and due to the cause(s) and manner as stated. vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	and manner stated.
	To the vithin To the compl	Σ	29b. Signature and title of certifier	29c. License number 29d. Datersigned (Month, Day, Y	
	10		30, Name and address of person who completed cause of death (Item 23a)		28 28
	Sta	l te	31. Date filed (Month, Pay Year) 32. Registrar's Signature	s lu Harvada Chace 216	المارو
	Registr		001 1 2 2018 Denue	parked	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Arminta Virginia Reynolds Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Boonsborg hrney-Keed 8. Date of Birth (Month, Day, Year) March 31, 1919 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 213-18-9768 Hours 93 1 🗆 M 2 🔀 Director Pennsylvania Arminta Virginia 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Completed by Funeral Director Maryland Washington Boonsboro 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8507 Mapleville Rd. 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 □ Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Substitute Teacher Board of Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leotta M. Carbaugh Charles William Fager, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13224 Little Antietam Rd. Hagerstown, MD 21742 Linda Hutto-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery 10-21-2012 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home hature f Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical disease or condition resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Reynolds, Arminda Virginia burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F OTHY OTH 🖎 Certifying Nursa Practitionar to the best of my knowledge, death oncomed at the time, date and place, and due to the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

JW-12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown

Ct.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:25 PM Kenneth Kobert Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Washinaton Funkhouser lear Koad If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Days Hours Director 07-15-1934 Maryland 28a-f show 10c. City, Town or Location by Funeral Director notified Spring Washington 1 🗆 Yes 2 No lear 10f, Zip Code 10e Street and Number 10g. Citizen of What Country? ō must be r 21722 Funkhouser items Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceuen. _ Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Secondary (0-12) agriculture College (1-4 or 5+) farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ samuel Keed Lebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12323 Funkhouser Road Clear Spring, MD 21722 Mills Reed wife Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Bia Pool 10-18-2012 4 ☐ Donation 5 ☐ Other (Specify) Cem. Thompson Funeral Home, Inc Clear Spring, MD 21722 22. Name and Address of Facility Donald Edwin P.O. Box 310 21. Signature of Funeral Service Licer Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ erebro Vasculur disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner wite Sequentially list conditions Physician/Medical Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a I be detached i Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? page 2 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 4 Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 160 83333

DHMH 17 Rev 06-2011

Registrar

State

30. Name and

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address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ruby Mae Rusten Physician/ Month Medical 4a. Facility Name (if not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Location of Death Cheverly 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Social Security Number 579-54-2361 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 68 **Director** 1 □ M 2 🔀 F 4-26-1944 S.C. Usual Residence of Deced show 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** MD P.G. Palmer Park 28a-f 1 Yes 2 No the ò . Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 7606 Muncy Rd. 23aPage 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
Black Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify 3 Midowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Private College (1-4 or 5+) Nurse Be 17. Father's Name *Eirst, Middle, Last)*John Foster 18. Mother's Name (First, Middle, Maiden Surname) Willie Mae Boyd ပ 19a. Informant's Name/Relationship (Type, Print) Kevin Rusten (S0n) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14917 Lear Ln. Silver Spring MD. 20905 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Cem . cemetery, crematory or other place) Date 20c. Location - City or Town, State 10 - 20 - 12Hyattsville MD. Harmony Nat"l 4 Donation 5 Dother (Specify) permit. Hunt Funeral Home 21. Signature of Funeral Service Licensee

Francis B. Hunt CC ²² Name and Address of Facility Hunt Fu 908 Kennedy St. N.W. (353)Wash, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ninuns burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 55.MG7 1700 Cumous certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No g Unknown ate has been signed by the a page 2 should be detached f P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.
To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 1 📈 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0053703 5JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 MS HOSPITAL DR. CHEVERLY BERHANE TSION . Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 10-8-2012 Physician/ 12:29 PM SHANNIE M. RUTLEDGE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Country) **Director** 577-32-8272 1 M 2 X F 86 12/24/1925 SC Usual Residence of Deced 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at Director MD PGLANDOVER 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number pe ?7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be Funeral 20785 USA 1805 VERMONT AVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PG GOVERNMENT 9TH CAFETERIA TECH Ве 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even and Mental F is marked o မ OMELIA FOWLER ABRAHAM BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRETCHEN C. HUNTLEY/ 6508 100TH AVE, SEABROOK, MD 20706 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FORT LINCOLN CEMETERY 10-17-2012 BRENTWOOD, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Licence once. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final CARDIAC Fatal Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No iniurv 1 Natural 5 Pendina Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who

31. Date filed (Month, Day,

DRIAGU, 420MA (MO)

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CHEVERLY

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 10^{Day} 2012^{Year} Physician/ Month I 0 7:50 P M Unistinene E. Roane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Center Laurel 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min (Month, Day, Year) 90 Director 197-14-4792 1 □ M 2X F 09/06/1922 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 X Yes 2 □ No Prince George's Lanham MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō Funeral with 1 items 23a USA 20706 5519 Center Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 2 X No 6 þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", Black 3

Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Civil Servant 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ Lovely Logan William Roane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5519 Center Avenue Lanham, MD 20706 19a. Informant's Name/Relationship (Type, Print) pe 1 and 2 sit of Health a Sean Roane/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1.
Department of I Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/18/12 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-Narch Funeral Home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiovascular accident Medical Due to (or as a consequence of **Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury Hypotension and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) n the past 12 months? or Attending Physician: The law requires that the death ò Day Pregnant at time of death 2X No Yes detached 1 ☐ Yes 2X 9 ☐ Unknown signed by t Id be detach Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Gout 24a Was an autopsy After this certificate has Yes 2 No 1 Yes 2 V No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2**X** No Other: 1 Yes ျ 1 Inpatient 2 I ER/Outpatient 3 -4 W Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Natural injury 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29b. Signature 10/17/12 D47867 JM address of person who completed cause of death (Item 23a) (Type, Print) Zuniga, MD 4701 Randolph Road Suite 101 Rockville, MS 20852 31. Date filed (Month, Day Y

DHMH 17 Rev 06-2011

State Registrar 2012

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death ROBINSON Month 34 PM Physician/ EEN 0 2012 Medical Name (if not institution, give street and number) 4c. County of Death **Examiner** HOSPICE -ISBUR DASTAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-24-1605 85 1 □ M 2💢 F Director 07-17-1927 MD or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits death with the Maryland 10a. State Director 1 X Yes 2 No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 13603 SeaCaptain Road 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc ō þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Medical Secretary Allegheny League 12 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, If once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be trent of Health and Menta Richard Lease Mary Skelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13603 SeaCaptain Road, Ocean City, MD. James F. Robinson-Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 10-17-2012 Berlin, MD. 4 Donation 5 Other (Specify) Sunset Memorial of Funeral S 22. Name and Address of Facility Burbage Funeral Home Sign 108 William Street, Berlin, MD. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Duvito (or as a nonsequence of): If any, reading to immediate cause. Enter Underlying the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnapt 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month been signed by the atter should be detached for Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 24 hours after death. Funeral Director. After this certificate has letely filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 11/0 1 Inpatient 2 ER/Outpatient 3 DOA မြ 1 Yes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending ▶ Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARE DR. SALISBURY DN 10 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lucia Martha Rice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 6 MountainYiew **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) Country 526-84-9925 **Director** 1 M 2 X F 78 Nov 7, 1933 Austria Usual Residence of Decedent 3a or 28a-f show t be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 ☐ Yes 2X No Lucia Martha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 31 Mountain View Drive 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 X Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Sewing Machine Operator Manufacturing Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Joseph Wagner Magdalena Gebhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : Jacquelyn Beall / executor 20944 San Mar Road Boonsboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Department Important: If any injury or Stauffer Crematory 10/16/2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of the large service Ligensee

22. Name and Address of Facility Bast-Stauffe

7606 01d National Pike Boo

23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caute on each line. 22. Name and Address of Facility Bast-Stauffer Funeral Home P.A. Boonsboro, MD Myocardial Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical of Vital Records, P.O. Box 68760 as the l Martha IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter d be detached for Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work?
1 Yes Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending injury 5 Pending 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Transfer of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIOUR 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 16 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ ·dIM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 343 McGrady Rd. Rising Sun Ceci If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 1 M 2 F 222-01-3981 95 12/1/1916 DE Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar must by nothing at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 343 McGrady Rd 21911 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify. 3X Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elmer McQuay Louisa Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Breslan/daughter 343 McGrady Rd. Rising Sun, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Ø Other (Spentombment Cathedral Cemetery 10/9/12 Wilmington, DE Signature of Funeral Service Name and Address of Facility • I • Foard Funeral Home, 11 S. Queen St. Rising 21911 a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neach line. 23a. Part 1. Enter the disease, or complications of shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sloian and te burial-transit Examine Due to for as a consequence of The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day signed by the at d be detached for Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 Division of Vital 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 4 Nursing Home ᅙ 1 🗌 Yes 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗆 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day)

32. Registra

s Signature

Michelle Renee Rodriguez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 35260

		- For State Registrar		(Certific	ate of	Death			Reg	g. No.		
Physician Medicál Examine	7	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year							3. Time of Death 1044 hrs				
		4a. Facility Name (if not institution Meritus Medical Cente		mber)		41	b. City, Town, or Hagerstown		of Death		4c. County Washing		
Funeral Director		206 47 2040	6. Sex 1 M 2 XF	7. Age (In)		thday) Yrs.	If Under 1 Yea Months Days				(MM/DD/YYY) 2-1963	Foreig	hplace (State or n untry) DE
Maryland 28a-f show any d at once.			NGTON	10c.	City, Town	or Location	rown			140	g. Citizen of Wi	hot Cour	10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sh		10e. Street and Number 19326 B LO	NGMEADO	W			10f. Zip Code 217	742			us)		iu y :
within 72 hours after death with the Maryland yiene. "Medical Examiner must be notified at once."	by runeral		1 Yes orced If Yes, Give Yea or Dates:	orces? 2 🔀 N	No .	If Ye	Decedent of His s, specify Cubar Yes 2 X No	specify:	Puerto Ri	can, etc.)		e, etc. WH]	
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MD 21215 d 2 should be fill lth and Mental F n 27 is marked numatic event, f		19a. Informant's Name/Relationsh DAWN DOMIN	nip (Type, Print)				Address (Stree						
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Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Service I	Licensee				ame and Address 9 N.W. F		BEK	RY-SHOM	RT FUNE	RAL 1996	HOME 3
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the thinaral force; page 2 should be decaded for use as	Completed									24a. Was a autops perform	ned?		topsy findings available completion of cause of
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier 1 Certifying Ph	hysician: To the besininer:On the basis	st of my kno of examinat	wledge, de	eath occurr	red at the time, d	ate and pla	ace, and discurred at t	ue to the cause the time, date a	e(s) and manne and place, and	er as stated	ed. ne cause(s)
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2 m		30. Name and address of person Ling Li, MD Assista	who completed cau			Baltimor	e Street, Bal	timore,	MD 212	23			
Sta Registr	_	31. Date filed (Month, Day, Year)	P. R	egistrar's Si		bark							
region	1	1171 A W. C	M 1 to (1) 100	-	-	W. W. W. W.							

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	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Bir	thplace (State or Foreign				
	Director		188-32-7450 Usual Residence of Decedent	□ M 2 😿 77	Yrs			May 26	, 193	35 Peni	nsylvania				
	yland f sho	ctor	10a. State 10b. County	10c. Ci	ity, Town or	Location					10d. Inside City Limits				
	or 28a notifi	Director	MD Howard 10e. Street and Number		Day	10f. Zip Code			10a Cir	tizen of What Co	1 ☐ Yes 2 🙀 No				
	filed within 72 hours after death with the Manyland al Hygiene. J other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral	13611 Voland Cour	t		2103	6			United S					
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Maryland	uld be d Ment marke natic e	10	Robert Kelly				Hazel	Robir							
Ma	12 shoulth and 27 is r		19a. Informant's Name/Relationship (T			ailing Address (Street a									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Arlene Shank Physician/ Joan Month Year 3:15PM 2019 tobe Medical 4a. Facility Name (If not institution, give street and number)
Meritus Medical Center 4b. City, Town, or Location of Death Hagerstown 4c. County of Death Washington **Examiner** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5-1-1938 Hours Months 74 218-34-4094 1 - M 2X F **Director** Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director MD Washington Hagerstown must be notified 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 23a 1033 Beachwood Drive 21742 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black White etc ò 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) residence Homemaker 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Martin Smith Lillian Romane Charles ^{19a.} Informant's Name/Relationship (*Type, Print*) spouse Daniel B.Shank Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 1033 Beachwood Dr. Hagerstown, MD 21742 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 28, Department of Important: If i any injury or conce. 1 X Burial 2 Cremation 3 Removal from State Oct Shank town Cem. Big Pool, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc Signature of Funeral Service Licensee M51414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocardia Physician/ disease or condition Medical resulting in death) sequence of): Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami SAP the burial-transit 5 ; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician boli Physician/Medical a P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No p Month Day Year Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performed death?
1 Yes 2 No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ည ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

2

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

MURSHED

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0060396

29d. Date signed (Month, Day, Year)

MO

11740

10/22/12

town

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER SEMLER 0.34PM JEAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNS HOPKINS BALTIMORE N/A 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 217-30-5920 1 □ M 2 🖾 F 76 Apr. 18, 1936 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Hagerstown Maryland | Washington 10e. Street and Numbe 10f. Zip Code r items 23a or ner must be n ö 10g. Citizen of What Country? Funeral 21742 1009 Fairview Road U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗵 No Specify: "natural", Specify: Completed 3 ☒ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Home Care Provider Domestic 10 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or est. Ethel Coffman Garfield Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Bryan Place, Hagerstown, Maryland 21740 Mary Gregory / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/23/12 Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licrosee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the guipo IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Geal Pregnant at time of death atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year the a ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy performed? Yes 2 N this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sup \) Residence \(6 \sup \) Other (Specify) 1 Yes 2 No ပ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 \square Pending work 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 OCTOBER 17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLEANS STREET BALTIMORE MD 21287 エルー6 1800 31. Date filed (Month. 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **7:00** Physician/ John W. Sparks 10718/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Harford** Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 04/07/1939 213-38-525 7 73 Director 1 **X** M 2 □ F Maryland 28a-f show 10a, State 10c. City Town or Location Aberdeen Director 10d. Inside City Limits Harford ms 23a or 28a-f s must be notified |MD|XXYes 2 No 10e. Street and Numbe 0f. Zip Code 210 0 1 10g. Citizen of What Country? Funeral 404 South Philadelphia Blvd. U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Black, White, etc. o, þ 1 Never Married XXMarried 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced and Mental Hygiene.

Is marked other than "natural umatic event, the Medical E) Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mechanical Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Be 61/8110 17. Father's Name (First, Middle, Last) und be filk th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Mary Bertha Cochran John W. Sparks Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town State, Zip Code)
Po Box 526 Forest Hill, MD 21050 t: If item 27 is Virginia Sparks/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of MD Cremation Center 10/23 2012 20c. Location - City or Town, S Hanover, MD 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, 4 Donation 5 Other (Specify) 22. Name and Address of Facility D'Alessandro Funeral Home 4522 Butler St. Ettsburgh, PA 15201 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner UMINARY TRACT INPECTION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events resulting in death) Last Physician/Medical CANCER, METASTATIC Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No Day Month 1 ☐ Yes ∠ ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE Completed 1 ☐ Yes 2 Probably 4 ☐ Unknown ACUTE KIDNEY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy OBSTRUCTIVE NEPHROPATHY performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No parks မြ 1 MInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I Andres Aparkowshi unD OCTOBBR 18, 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDRON NONAKOWSKI MP 35 FULFORD AVE BELAIR MO 2/05

DHMH 17 Rev 06-2011

State Registrar 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ambric 8. Date of Birth (Month, Day, Year) 4 -0 3 - 1930 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 D F Months Days Min. 2 60 **Director** Maryland Residence of Deceden , or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral U 5 Koao 12. Was Decedent Ever in U.S Armed Forces? 1 12 Yes 2 1 No 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 No 1952 Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced Black Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Trucking and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ evens 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Road Cambridge tannie 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) eterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home : naton eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ MYELODYSPLASTIC SYNDROME disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ó Month Dav Year detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔽 Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D39887 10-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH DR. DAVID 8221 DRIVE EASTON, MD 21601 TEAL

Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2012 7:14 PM Jean Denise Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's aurel Regional Hospita Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Hours 577-76-7693 Usual Residence of Decedent 1 🗆 M 2 🔀 F 56 Wash. DC 11/11/1955 10c. City, Town or Location 10d. Inside City Limits Prince Georges Laurel 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9558 Muirkirk Rd. #122 20708 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary 12th <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Smith Elma Charles Smith . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2077219a. Informant's Name/Relationship (Type, Print) 6304 Gold Yarrow Lane, Upper Marlboro MD. Anita Smith Leach/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/24/2012 Clinton, MD Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Prvice 22. Name and Address of Facility DL McLaughlin Funeral CC0257 2518 Penn. Ave. SE Wash., DC 20020 plications that caused the decone cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List Onset and Death Immediate Cause (Final Intestina ecrosi disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If 23d. Date of delivery су Month Day Year

Physician Medical Examiner

and

the attending physician

been signed by

Department of Important: If any injury or once.

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items

ı "natural", or item edical Examiner n

Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical

Director

Funeral

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Completed

Be

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical

the burial-transit should be detached for after death.

Director: After this certificate has a section of the section of th page 2 filled in by the

Completed by

Certificate: To Be

Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IE EELAALE
IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
in the past in the state of the

yes, outcome of pregnancy	
Live Birth 2 Fetal death	3 Ectopic pregnan
Pregnant at time of death	5 Other (specify)
T t Inleneum	1 / 2/ -

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

art II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	
		_

	24a. Was an autopsy performed?
26. Place of Death (Check or	nly one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

	1 Yes 2	No	Н
27	. Manner of Deat	h	
	1 Natural	5 Pending]
ı	2 Accident	Investiga	
ı	3 Suicide	6 Could n	ot be

25. Was case referred to medical

(Check

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

4 Nursing H	ome 5 Residence	6 Other (Specify)
ury at ork?	28d. Describe how inj	ury occurred

4 Homici		28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, offic
29a. Certifier	1 Certifying Physic	an: To the best of my knowledge.	death occurred at the t

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7300 Van Dusen Road

only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deat	h occurred at the time, date and place, and due to	the cause(s) and manner as stated.
9b. Signature and title accertifier	29c. License number	29d. Date signed (Month, Day, Y
M.D.	D\\(\pi\63580	October 17,

2 2012

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) October 17, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mina Yacoub, M.D. Laurel Regional Hospital Yacoub, M.D.

State Registrar

DHMH 17 Rev 06-2011

FIM

within 24 hours a To the Funeral I To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Steen Month 10/14/2012 13:07 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Prince Georges Hospital Cheverly Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8, Date of Birth Months Days (Month, Day, Year) Director 1 🗆 M 2 🗶 F 100-14-8994 88 Yrs 02/21/1924 New York Usual Residence of Decede 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Prince Georges Lanham 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8908 Spring Ave. 20706 USA items ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, med Forc Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates White 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: Health and Mental Hygiene.
Health and Mental Hygiene.
tem 27 is marked other than "naturother traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chas Appenzeller Agnes Appenzeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Steen (Son) 8908 Spring Ave. Lanham, MD 20706 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Long Island Nat. Cem. 10/18/2012 Farmingdale, MY ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Rencon/Hale Funeral Tome ignatur of Funer Servic Cicens 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir burial-transi resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) for in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day ed by the at detached for Year 9 Unknown Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate | Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မြ After this 1 ☐ Inpatient 2 € ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ieral Director: Al filled in by the fu after death 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical within 24 hound to the second 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of proprieting and/or investigation, in my opinion, doth occurred at the time date and place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier . License number 29d. Date signed (Month, Dav. Year) Sm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHEVERLY, MD. 20785 3001 31. Date filed (Month, Day, State 32. Registrar's Signature A Banger Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #20b & 20c Per FH Centificate of Death 35268 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Frederick Montgomery Smith October 9, 1215 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's <u>Cheverly</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Hours Min. Director 579-46-6037 1 🖾 M 2 🗆 F 78 Usual Residence of Decedent Sept. 10c. City, Town or Location at 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 X Yes 2 No Maryland | Prince George's Largo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 12908 Fox Bow Drive Apt. 204 20774 United States ral", or items : Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces' , or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 X Yes Specify: African Amerian 1 Yes 2 No Specify: If Yes, Give "natural", Completed 3 XWidowed 4 Divorced Year or Dates er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Mental Hygiene. of Health and Mental Hygien item 27 is marked other the other traumatic event, the Stock Clerk Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leonard Smith Estelle Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Estelle Alston - Sister 1103 Dartford Lane Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lincoln Cemetery 18/12 4 ☐ Donation 5 ☐ Other (Specify) Ft. Brentwood, MD unk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Veaps Physician/ DISEASE ON DIAYSIS KICINCA STAGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of): the burial-transit resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery led by the atter 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARKRY 1 Yes 2 No 3 Probably 4 Unknown page 2 should DISERS. 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

2 Hours after death.

5 Funeral Director: After this certificate has letely filled in by the funeral director, page 2. performed? Yes 2 No 1 Yes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ဂ 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I only one) Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway CTR PRIVE, Greenbalt, MD CHAK MD TEUEN

DHMH 17 Rev 06-2011

State Registrar 1. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item For State Registrar 10/16/12, per physicianertificate of Death D.H. 2. Date of Death 10/11/2012's Name (First, Middle Last) 3. Time of Death Physician/ 16:55 singleton Medical 4a. Facility Name (if not institution, give street and number 46. City. Town, or Location of Death **Examiner** altimore 8. Date of Birth
(Month, Day, Year)
May 15, 9. Birthplace (State or Foreign 7. Age (In yr **Funeral** 8 217-69-6257 1 🗶 M 2 🗆 F Director 2004 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at 10a. State Director 1X Yes 2 No Pocomoke City MD Worcester 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? ō items 23a Funeral 21851 USA Bradley Court death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No ö 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: AfricanAmer. "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student and Mental Hygier is marked other t other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental h Important: If item 27 is marked any injury or Alba Melissa Kelly Toledo Michael Duane Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley Court, Pocomoke City, MD 21851 Melissa K. Toledo/ Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/22/2012 Salisbury, MD 21804 Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home, P.A., 21. Signature of Fundral Service Licenses 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a detached f P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1100 death? within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital 2 1 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORleans St. Baltimore cel 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 2012 Bente Greve Selby 10:40 A.M 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 6900 Lord Baltimore Drive Calvert Owings Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday, Months Days Hours 1 M 2 X 0472471939 Denmark 577-66-6875 73 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Calvert MD 1 Yes 2 No Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6900 Lord Baltimore Drive 20736 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) accountant/ credit manager trade association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unobtainable Else Elizabeth Svennson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy E. Selby, daughter P.O. Box 1091, North Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/17/2012 Alexandria, VA Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final extensive stage small cell lum disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF

Physician/ Medical Examiner

Department of Heath Important: If item 27 any injury or other to once.

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

ğ

Completed

Be

2

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Physician/Medical ģ Completed Be

27. Manner of Death

1 🗷 Natural

Accident

29b. Signature and title of certifie

Kenneth L. Abbott,

☐ Accider☐ Suicide

4 Homicide

29a. Certifier (Check

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signat

6 Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Certificate:

Division of Vital Records, P.O. Box 68760

SM 10 State

	d		
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	Loor Bid tobaco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed;	
5. Was case referred to medical examiner?	26. Place of Death	h (Check only one)	2 T 2 U 1/2 V 2

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1) 56024

110 Hospital Road # 110, Prince Frederick, MD 20678

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

October 16 COIZ

DHMH 17 Rev 7/2009

Registrar

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Μ

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year)

Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clark Summers Robert 31 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany City, Town, or Location of Death **Examiner** Cumberland WMHS-RMC 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours oyan 27% 1919 234-26-7407 1 Å M 2 ☐ F 93 **Director** 28a-f show 10c. City, Town or Location **Horner** 10d. Inside City Limits the Medical Examiner must be notified at Director Lewis 1 🗆 Yes 2 🏲 No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 26377 P.O. Box 13 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Arrixed Forces' ² NowII Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give white 'natural", 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) USPS postmaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dona Duncan permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked c ary injury or other traumatic eve once. Creed Summers ဂ 19a. Informant's Name/Relationship (Type, Print) Alicia White 19b. Majing Address Street and Number or Rural Route Number City of Town, State, Zip Ood 26377 daughter 20a. Method of Disposition
1 Derial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 10/15/2012 WV WV National Cemeters Grafton Panation 5 Other (Specify) 22. Name an Scarpellif Faumeral Home, PA 21. Sign ture f Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line 23a. Part 1 Approximate Interval Between Onset and Death Immediate Gluse (Final disease or andition resulting in death) ACUTE RESPIRATORY Physician/ Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLISM Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year s been signed by the should be detact Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SUBDURAL HEMATOMA 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Yes Hospital Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 10-8-12 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined NORSIN G AWN Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0071867 address of person who completed cause of death (Item 23a) (Type, Print) WILLOW BROOK RD. CUMBERLAND, MD 21502 1250D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 1 2 3 5 2

		•	For State Registrar	State of Ma	arylanu / i		tificate of L		ria ivie	entai Hy	gien Reg. N	201	2	352	73
	Physicia		1. Decedent's Name (First, Middle Robert	e, <i>Last)</i> Donald	Spang	gler				2. Date of De Month	D		ear	3. Time of Dea	ath M
	Medic Examin		4a. Facility Name (if not institution	, give street and number)			4b. City, Town, or	r Location of	Death	(0	4	c. County of	Death	1840	141
C.S.			Western MD Reg		.1 Cente		If Under 1 Year	mber If Under 24	_	8. Date of Bir	th	Alle		ace (State or Fo	roian
	Funeral Director		215-26-6298		0	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	1	Counti		_
	ind show at	ا ا	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Loc	ation							Od. Inside City Li	
	Maryla 28a-f otified	Director	MD Alle	gany	LaVa	le								1 🗆 Yes 2	X No
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral D	10e. Street and Number 59 LaVale Bo	oulevard			10f. Zip Code 2150	2			10g. C	Citizen of What USA	at Count	ry?	
ဖွ	ter death , or item iminer m	by Fur	11. Marital Status 1 □ Never Married 2 ☒ Mai	12. Was Decedent E Armed Forces? 1 X Yes 2 1 If Yes, Give			as Decedent of H Yes, specify Cuba		n? (Speci Puerto Ri	fy Yes or No- can, etc.)		14. Race - Black,	America White, e		
-003	ours af atural" sal Exa	eted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes 2 X No					Specify:		hite	
21215-0036	nin 72 hi se. shan "na e Medic	Completed		est grade completed) College (1-4 or 5-		(Give ki	ent's Usual Occup ind of work done of NOT use retired)	during most o	of working	7		Kind of Busin		-	
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ylan	ld be filed Mental Hy, arked oth atic event	욘	Robert	Jerome	Span	gle:	r	Anna				Lamber	ct		
, Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Barbara Spangle				y Address (Street a Vale Bou					or Town, Stat 21502		ode)	
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Durial 2 K Cremation	3 Removal from State	20b. Place of cemeter	f Dispos ry, cremi	ition (Name of atory or other plac	ce)	Da	te	20c.	Location - Ci	ty or Tov	vn, State	
altin	# P E E		4 ☐ Donation 5 ☐ Other (*	Cumber	lan 22.	d Cremat Name and Addres	orv: 1	10/22 Adam	/2012 s Fami	ily	Lumber Funer	land al H	MD ome, P.	Α.
m	permi Depar Impol any ir		Mour SI	Marro		988	404 Deca	tur St	creet	, Cumb	perl				
	Inysician/		shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused only one cause on each line.		A	the mode of dyin	g, such as ca			rest,		1	Approximate Interval Betweer Onset and Death	n n
4	Medical Examiner		resulting in death)	Due to (or as a	conseq 3 ce c	of):	1								
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09/	icate be e g physiciar ts the buri	ledical		d									\perp		
g	ertifica Iding pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy							23d. Date of	of dolivor	2/	
	requires that the death certificates signed by the attending posterould be detached for use as	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown			Ectopic pregnand Other (specify)	;y				Month		Day Year	
й, О	law requires that the nas been signed by tl e 2 should be detach	by	Part II. Other significant condition	ons contributing to death bu	ıt not resulting i	n the un	derlying cause giv	ven in Part I.						e cause of death	
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ž	The ate I	Com							_	autor perfo 1 \square Yes	osy ormed?	dea		pletion of cause	e Of
Ita	sician: certific	8	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital:			_ Othe	ace of Death	,			. [7]			
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sion	I or Attendii after death, Director: A d in by the fu	Certificate:	2 Accident Investi 3 Suicide 6 Could	gation not be			M 1 🗆	Yes 2 □ N	-	of Location (S	etroot o	nd Number o	r Dural E	Route Number,	
2	tal or / rs after al Dire led in b		4 ☐ Homicide determ	building, etc.	(Specify)					City or Tow	ın, Stat	e)			
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 L Medical B	Physician: To the best of n xaminer: On the basis of ex Nurse Practitioner: To the	amination and/o	r investig	gation, in my opinic	on, death occu	urred at th	e time, date a	nd plac	e, and due to	the caus	se(s) and manner	stated.
1	To the Comp		29b. Signature and title of certifier		beet of my kilot	ricago, c	29c. License	number				ate signed (A			
	5+		30. Name and address of person	who completed cause of de		Type D		0033	SLY	U	0	ctobe	25 3	20,200	
	las		Sunil K. Gupt	a, M.D., 62	5 Kent	Aver	nue, Cum	berlan	d, M	D 215	02				
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	32. Registrar		Ked	,								
				Married Marrie	- Marie										

DHMH 17 Rev 06-2011

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amend #19are of Maryland 7 Department of Health and Mental Hygiene

		-	for State Registrar	Otat	or iviary		tificate of L			Reg. No. 20	12	35274												
	Physicia	in/	Decedent's Name (First, Laura	Middle, Last) Leota	a	Smith			2. Date of Dea	Day	Year	3. Time of Death												
-T7	Medic Examin		4a. Facility Name (if not ins	titution, give street and		Officer	4b. City, Town, or	Location of Death		4c. County		1125												
	_		WMHS-RN 5. Social Security Number	//C 6. Sex	7. Age (In yrs. last birthday) If U			imberl If Under 24 Hrs.			egat 9 Birthn	lace State or Foreign												
	Funeral Director		214-07-229	0 1 □ M 2 🗗			Months Days	Hours Min.	Tan 5	† 1 913	Count	ryWV												
	and show dat	tor	Usual Residence of Dece	County -Bedford	10c	. City, Town or Lo	lation	1 1			10	Od. Inside City Limits												
	Maryli 28a-f notifiec	Jirec	WV Mi	neral		Fort Asl	1by 10f. Zip Code	26710				1 XXYes 2 1 No												
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 194 Pine F	Diane Diive I . O. Dox 000 20/13						10g. Citizen of	USA	.ry?												
	death ritems iner m		11. Marital Status	12. Was [Arme	Decedent Ever in d Forces y Yes 2 ☐ No	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e													
920	rs after iral", o	ed by	1 Never Married 2	. If Yes	/es 2 ∐ No , Give or Dates.		☐ Yes 2 ☐ No			Specify	wł	nite												
21215-0036	72 hou n "natu Tedical	Completed	(Specify on	ecedent's Education ly highest grade comple			16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)			16b. Kind of B	Kind of Business/Industry													
212	within rgiene. ner thau		Elementary/Secondary	(0-12) Colleg	ge (1-4 or 5+)	retire	ed owner			Laura's	Pet	3hop												
and	should be filed within 7: and Mental Hygiene. is marked other than raumatic event, the Me	To Be	17. Father's Name (First, M Thomas	iddle, Last) Jefferson H	Hearton			18. Mother's Nar Laura	me <i>(First, Middle, E</i> Farnswor	Maiden Surnam th	e)													
Maryland	27 th 27 tr		19a. loformant's Name/Re Thomas Sm	lationship (Type, Print) I TN	son	19b. Mailin	36 Sharp	Road Number or Ru	iral Route Number	nelg	State, Zip C	1D 21737												
ore,	Page 1 and ment of Heal ant: If item ; ary or other		20a. Method of Disposition	nation 3 🗆 Removal	rom State	Db. Place of Dispo	sition (Name of patory or other clad remorial Ga	ardens	Date 10/18/201	20c. Location		wn, State												
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 21. Signatur of Funer S	// //	1		. Name a 364 p	elli•Femeral l																
	40200		23a. Part 1. Enter the die	ase, or complications t	hat caused the d		nia Avenue: Cumberland, MD 21502 uch as cardiac or respiratory arrest, Approximate																	
Sik	Physician/		Immediate Cause (Final disease or condition	e. List only one cause o	n each line.	ral	preim	mie				Interval Between Onset and Death												
1	Medical Examiner		resulting in death)	Due	e to (or as a con			16 her																
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68760	<u>∞</u> 50 %	/Me	IF FEMALE: 23b. Was decedent pregna	23c. If yes	, outcome of pre	egnancy				22d D	ate of delive	in.												
Вох	e death certif the attending ched for use a	Physician/Medical	in the past 12 months 1 Yes 2 No 9 Unknown	? 1 1 4 1	1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown			су				onth Day Year												
s, P.O.	or Attending Physician: The law requires that the death certivater death. Director: After this certificate has been signed by the attendinin by the funeral director, page 2 should be detached for use.	ρ	2	2	2	ρ	ρ	by	by	þ	by	by	by	þ	Part II. Other significant of	onditions contributing	to death but no	t resulting in the u	nderlying cause gi	ven in Part I.		4		e cause of death?
cord	law requires been been been been been been been be	Completed							24a. Was a	osy	prior to cor	psy findings available inpletion of cause of												
l Re	ician: The la certificate ha rector, page		25. Was case referred to m	edical			ac D	ace of Death (Che	1 Yes	rmed? 2 X No	death? 1 Yes	2 🗆 No												
Vita	Physician: this certificaral director,	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	1 Ninpatient 2	2 ER/Outpatier	Oth	or:	Home 5 Resid	lence 6 🗆 Oth	er (Specify)													
J of	ding Ph h. After th funeral			Pending	Date of injury Month, Day, Yea	28b. Time of injury				8d. Describe how injury occurred														
Division of Vital Records,	I or Attendir after death. Director: Af d in by the fu	Certificate:	2 Accident 3 Suicide 6 4 Homicide		28e. Place of Injury - At home, farm, street, factory, office 28f, Location						n (Street and Number or Rural Route Number, own, State)													
۵	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E	Medical C	29a. Certifier 1 Ce	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the						ner as state	id.													
	To the Hu within 24 To the Fu complete	Me		rtifying Nurse Practiti				the time, date and p	place, and due to t		manner as s	tated.												
	, べ,		► va	100	MD.			073719		<u> </u>	October 14, 2012													
	. 0		30. Name and address of	person who completed	cause of death ((Item 23a) (Type, F	Print)					1160 2												
	Stat	te	31. Date filed (Month, Day	17 2012	2. Aegistrar's Si		w brook	KD (1)	umverle	and m)D 0	71209												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHAFFER Physician/ Month LEE 2:20 PM tobe 2019 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Lions Center Allegany Comberland Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-22-5288 **Director** 1 🗆 M 2 🔀 F 11/11/1926 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified Cumberland 28a-f MD Allegan 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral Drive 21502 Seton 901 USA permit. Page 1 and 2 should be filed within 72 hours after death "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than ". Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 2 7 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BURKETT KATHRYN CLYOE TRVIN AMELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 is or other tra Kodney I Shaffer Son HYNDMAN PA 15545 Po Box 87 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State : If 1 🗷 Burial 2 🗆 Cremation 3 🗷 Removal from State Department or Important: If any injury or once. HYNDMAN CEMETERY 10-20-2012 HYNDMAN 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER F.H.INC Signature of Funeral Service Licenses 169 Clarence St Hyndman PA 15545 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Concer disease or condition resulting in death) 6marthy onsequence of) Medical Due to (or as Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death the Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has I autopsy 1 Yes 2 No 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗷 No Hospita ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural .vatural
Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 20055321 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend 23a,27, per me, g934 12-4-12 sm
State of Maryland / Department of Health and Mental Hygiene amend #26, per ME, g934, 12-7-12 sm

Certificate of Death

Reg. No 2 0 | 2 State Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCT Day 2012 **SMITH** MONICA 4:44 P M JOY 09 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MALCOLM GROW MEDICAL CENTER PRINCE GEORGE'S JOINT BASE ANDREWS Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Min. Hours 524-63-9858 AUGUST 5, 1981 Director 1 □ M 2 🛛 F COLORADO 31 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGES ANDREWS AIR FORCE BASE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200-2 ATLANTA AVENUE 20762 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working i end Mental Hygiene, is merked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ be ARNOLD LEIGHTON, JR. KATHLEEN C. BOSCH plnous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health e tent: If item 27 is MAJ HARVEY C SMITH,III/HUSBAND 2200-2 ATLANTA AVENUE ANDREWS AFB, MD 20762 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Depertment of Importent: If it eny Injury or o 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MAYERDALE CREMATORY NEWARK, DE 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOME 1000 N DUPONT PKY NEW CASTLE, DE 19720 253. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PENDING Multiple Drug Toxicity disease or condition Medical resulting in death) Due to (or as a consequence of) kaminer Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the control of the control for use es the burlal-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month isigned by the et ald be detached for Pregnant at time of death Day Year 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate funeral director, pag performed? 1 Yes 2 KNo 1 X Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🗷 Residence 6 C Other (Specify) ဍ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred □ Natural work? patient consumed a toxic eral Director: A filled in by the fi Accident 10-9-12 2 🗶 No Investigation 12:00 p^M of multiple prescription medications 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nymber or Rural Route Number, City or Town, State) 2200 Atlanta Ave. Unit 2 Andrews Airforce Base, MD. 4 Homicide determined At Home Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29d. Date signed (Month. Day, Year) VA 0101102718 Jolomon CIDR MC USA OCT 11 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER CAROL J. SOLOMON, BETHESDA, MD 20889 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of	f Maryla		artment of tificate of		and M		giene, Reg. No.!	/ 11 /	35277
	Decedent's Name (First, Middle, Last)							Doutif		2. Date of De			3. Time of Death
Physician/ Medical Charles Fredwick Smith										October 10 201		0 2012	7:00 P ^M
Examir		4a. Facility Name (if not instit	4b. City, Town, or Location of Death				4c. County of Death						
,		42 Remington 5. Social Security Number	last birthday)	Port De		24 Hrs. 1	8. Date of Bir	Ced		thplace (State or Foreign			
Funeral Director		252-70-7429	6. Se	X M 2 □ F	66	Yrs.	Months Days Hours Min. (Month, Da.			y, Year)		untry)	
no d		Usual Residence of Deced			10- 0					2/28/	1946		GA
ırylanı a-f sh	Director					ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
he Ma or 28a e notif	Dire	MD Ce	cil		Po	ort Depo	OSÍT 10f. Zip Code				10a. Citi	izen of What Co	
with t	Funeral	42 Remington	Road				21904				Unit	ted Sta	tes
death items ner m		11. Marital Status		12. Was Deced	ces?	l.S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
after al", or xami	d by	1 ☐ Never Married 2 🛭 3 ☐ Widowed 4 ☐ Dive		1 X Yes If Yes, Give	2 🗆 No es.1967-	1074	☐ Yes 2 🗶 N	lo Specify:			5		ite
hours aft	Completed	15. De	cedent's Ec	lucation	es.1907-	16a. Deced	ent's Usual Occu	upation			16b. Kir	nd of Business	
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difference of every	To B		, ,	th Cm						(First, Middle,	Maiden S	Surname)	
al yi		Allen Wesle 19a. Informant's Name/Rela				19b. Mailin	g Address (Stree			1ford Route Numbe	r. City or	Town, State, Zi	p Code)
Inc., IMAILYIGHIU ZIZIOCOOO 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Joyce Smith	/ Wi	fe		11	emington						ŕ
e 1 and 2 s t of Health if item 27 i		20a. Method of Disposition 1 Durial 2 K Cremi	ation 3	Removal from 5	20b.	Place of Dispo			_	^{ate} 2012		cation - City or	
permit. Page 1. Department of 8 mportant: if it my injury or of		4 Donation 5 Ot	her (Specify)		T. Foar	d Funer	al Hom	ie, P	.A.		ing Sun	
permit. Page 1 Department of Important. If it any injury or o		21. Signature of Funeral Ser	vice Lice s	orne	i f		Name and Addi						ome, P.A. 11
100	0	23a. Part 1. Enter the disease shock, or heart failure.	se or comp List only or	lications that ca	aused the dea								Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	1000	a						ncer			Onset and Death
Medical Examiner		resulting in death)		Due to (o	or as a consec	quence of):	•						
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):											
uted d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
exec ian an urial-tr	Ě	resulting in death) Last Due to (or as a consequence of):											
cate be executed physician and the burial-transit	edical			d									
or Attending Physician: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	√Me	IF FEMALE: 23b. Was decedent pregnant	. 2	23c. If yes, outc							2	23d. Date of de	livery
eath of for u	Physician/M	in the past 12 months?	Ectopic pregnal Other (specify)				Alax.	Month Day Year					
that the dea ined by the a	Phys	g 🗌 Unknown		9 🗌 Unkno						1			
s that igned be de	ğ	Part II. Other significant co	nditions co	ntributing to de	ath but not re	sulting in the u	nderlying cause (given in Part I.					the cause of death?
requires the been signed should be a	Completed												robably 4 X Unknown
law r has b	шb									24a. Was autor	osy	prior to	topsy findings available completion of cause of
ysician: The law I is certificate has t		25. Was case referred to med	dical				26	Place of Deat	h (Chack		rmed? 2 X No	1 🗌 Ye	s 2X No
ysicia ysicia is cert direct	To B	examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	-	lospital:	npatient 2 🗆	☐ ER/Outpatien	I _{Ot}	hor:			dence 6	Other (Spec	eifv)
ng Ph Ifter th		27. Manner of Death 1 X Natural 5 □ P	ending	28a. Date of		28b. Time of injury	28c. Inju			8d. Describe h			<i>50</i>
tendii death. tor: Ai the fu	Certificate;	2 Accident In	vestigation ould not be				M 1 [Yes 2	_				
al or At s after of Direct		4 Homicide de	etermined		of Injury - At h g, etc. (Speci		et, factory, office		2	8f. Location (S City or Tow		l Number or Ru	ral Route Number,
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director. After completely filled in by the funeral	Medical	(Check 2 L Medi	ical Examir	ner: On the basis	s of examination	on and/or invest	ccurred at the tir gation, in my opir death occurred a	nion, death oc	curred at t	he time, date a	ind place,	and due to the	cause(s) and manner stated.
To the within To the сопр		29b. Signature and title of ce	ertifier	Mar			29c. Licen	se number			29d. Date	e signed (Monti	h, Day, Year)
				136/		MD	D	006	219	0	10	111/1	2
5		30. Name and address of pe	rson who co	INE H	of death (Ite	m 23a) (Type, P AN Itw	Y, SHAH	NAWA	1Z I	LHAN ESTP	MD EXIC	ECIT	1,MD21915
Sta	te	31. Date filed (Month, Day 1	122	32 Re	o'strar's Signa	ature	1			,			
Registra	aı		do Fel L	014	MERCHA	19 1	arkel_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carol Ann Thomas October 18 2012 5:10 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20927 Mt. Aetna Rd. Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan. 14,1938 Days 1 M 2 X F 028-30-1521 New York 74 Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified Maryland Washington 28a-f Hagerstown 1 Yes 2 No 10e. Street and Number 10f, Zip Code 5 10g. Citizen of What Country? must be 23a 20927 Mt. Aetna Rd. 21742 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ò 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Etementary/Seconday (0-12) Finance Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Laverne Sims Dorothy Arlene Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Kenneth D. Thomas-husband 20927 Mt. Aetna Rd. Hagerstown, MD 21742 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Beaver Creek Cemetery 10-19-2012 | Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses Kaitlin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a, Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months 1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 2 No Yes 2 🖵 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 362 and address of person who completed cause of death (Item 23a) (Type, Print) JN-10 1 225

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont)

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 5.00 AM **Physician** Howard Taylor /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury arsons Wicomico | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-25-1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1₩ 2□F 73 Yrs MD 214-36-5932 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County or than "natural", or items 23a or 28e-f show the Medical Examinations be collified at 1 ☐ Yes 2 ☐ No Director LID Wicomico Pittsville 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 7310 Pine Street 21850 <u>USA</u> Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23. Iry or other traumatic event, I'm Medicul Exame or inust Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 No 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Howard W. Taylor, Sr. Ella Shiffer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Records-sis-inlaw 7310 Pine Street, Pittsville, MD. 21850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Pittsville Cem. 10-18-12 Pittsville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William Street, Berlin, MD. 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASWD 1041913 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth 2 Fetal death Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the al d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No certificate 1 Yes Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence Other (Specify) JB Parson 3 DOA 2 this 28d. Describe how injury occurred 45515 holling 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ochber 16th 2012 Who Nah D051359 30. Name and addr set of person who completed cause of death (Item 23a) (Type, Print) MT HER MON RUAD. SAUSBURY MD 21804 DR-45HA 951. NATESAN 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 Mont 2012 8:10 Ann H. Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 1 □ M 2 🕱 F 577-28-6422 Yrs MO 90 Usual Residence of Decedent June 8. 28a-f show 10a. State 10c, City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD Calvert Port Republic 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 1894 Parker Creek Road 20676 United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 🕱 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Catholic Charities Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Haynes Mary Catherine Gutherie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st f Health a item 27 i Mary Millsack / Daughter 2846 W. George Mason Road, Falls Church, VA 22042 other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 10/19/2012 Washington, DC Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · Htheroscienotic Cardiovas cular disease Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Day Month Year 1 ☐ Yes ∠ y 9 ☐ Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Records, 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Anoemia autopsy certificate has performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: <u>-</u> 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. 50653 10-15-2012 wond 1

KW 7 State

Registrar

DHMH 17 Rev 06-2011

31. Date filed

Chuzebton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

GYON C. SURANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vairimu Thande		1- For State Registrar	tate of Marylan		rtment of F tificate of E		id Mental	R	20 eg. No.	12 3528	
Physicia Medical Examin		1. Decedent's Name (First, Midd Wairimu		hande				2. Date of Dea Month October 1	Day Year	3. Time of Death 1318 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4250 Knox Road # 2210 C 4b. City, Town, or Location of Death College Park Prince George									
Funeral Director 5. Social Security Number 6. Sex 7. Age (In 19 or 19						If Under 1 Year Months Day				e. Birthplace (State or oreign Country) Kenya	
яну		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City I									
A	MD Charles Waldorf 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country							1 XYes 2 No			
with the Maryland ns 23a or 28a-f sho be notified at once	I Director	5704 Night S				20	603		US	Country?	
fter death	y Funeral								merican Indian, Black, tc. Black		
hours at fortural	ted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decedent's	Usual Occupa			16b. Kind of Busin		
5-0036 led within 72 hours at Hygiene. I other than "natural in Medical Examination of the Medical Exa	Completed		2	JI 3+)	st	udent				ivate	
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygiene. n 77 is marked other than numatic event, the Medica	Be Co	17. Father's Name (First, Middle Thande Niu	, Last) .guna					ame (First, Middle, I garet 1	Maiden Surname) [hande		
Z. p 9 5 3	2	19a. Informant's Name/Relations Thande Njugu	ship (Type, Print)		1	,			mber, City or Town, S Waldorf	State, Zip Code) MD 20603	
2 6 8 7		20a. Method of Disposition 1 Second Burial 2 Cremation			lace of Dispositio	n (Name of ce		Date	20c. Location - Cit		
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Jiale	ritage	Cemet			Waldor	f, MD uneral Home	
Bal Dermi Depa Impo	1	Mulry (1	3W/000		229	94 old	Wash:	ington F	Rd Waldo	rf, MD20601	
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.							Approximate Interval Between Onset and Death	
)		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.									
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.									
uted nd ransit	Exal	events resulting in death) Last Due to (or as a consequence of): d.									
50, te be executed tysician and burial - transit	edical	X UNPENDED	x AMENDED 23, per	а,27,28 me,g9	3a-f.per 39 5-14-	me,g9 13 sm	33 11-8	3-12 sm			
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	2 I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✔ Un	4 Pregnant	at time of dea	2 Fetal	death 3 (Specify)	Ectopic pre	egnancy	23d, Date of del Month	ivery Day Year	
that the deatled by the att		1 Yes 2 No 9 ✔ Un	3 Olikiowii	ath but not res	sulting in the und	erlying cause	given in Part I.	23e. Did to	obacco use contribut	te to the cause of death?	
S, P.O. uires that the signed by lid be detacl	ed by								s 2 ✓ No 3		
of Vital Records, ng Physician: The law required this certificate has been signeral director, page 2 should be a second to the second the secon	Completed							24a. Was autop perfo	prior deal	re autopsy findings available r to completion of cause of th? Yes 2 No	
= # E 5	å	25. Was case referred to medica examiner?	(Hospital:	tient 2 E	ER/Outpatient 3		Other		Residence 6	Other: Scene	
ision of Vita Attending Physicia ar death. rector: After this ce tector: by the funeral direct	낊	1 Yes 2 No 27. Manner of Death Natural 5 Per	28a, Date of I (Month, Da	njury :	28b. Time of Injur	y 28c. Inju	ıry at Work?	28d. Describe	how injury occurred		
Division pital or Attendiours after death. cral Director: Afilled in by the fi	Certification:	2 Accident Inve	stigation 28e. Place of		fd 1:06 p	om	Yes 2 X No	lalcohol		drugs and or Rural Route Number, City ox Rd. #2210C	
0~ = 5		29a. Certifier (Check only 1 Certifying P	hysician: To the best of					and due to the caus	se(s) and manner as	stated.	
To the How within 24 h To the Function	Medical	one) 2 Medical Example 29b. Signature and title of certific	uminer: On the basis of e and manner state er		d/or investigation	29c. Licens		ed at the time, date		(Month, Day, Year)	
		0-0-	*			O.C.	M.E.		October 20, 2	:012	
pa-1		 Name and address of persor Donna M. Vincenti, M 	D Assistant Med	ical Exam	iner 900 W	. Baltimore	Street, Ba	iltimore, MD 21	223		
Sta Registr	ite ar	31. Date filed (Mont) (172)	4 2012 32. Begis	trar's Signature	b. par	es!					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Yolanda Theresa Taccino 18 October 10:15 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Golden Living Center Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 02/06/1921 West Virginia 213-40-3410 **Director** 1 □ M 2 🛛 F 3a or 28a-f show be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21502 402 Pine Avenue must ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. White Completed Specify: 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Bone. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Home Homemaker 17. Father's Name (First, Middle, Last)
DelSignore Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Ann Gentile Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Mustaphal Drive, LaVale, MD 21502 James R. Taccino / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Restlawn Mem. Gardens 10/23/2012 LaVale, MD Donation 5 Other (Specify) of Funeral Jervio 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Part 1 Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronau Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) icense number

State

Registrar

DHMH 17 Rev 06-2011

625 Kent Avenue, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

31. Date filed (Month, Day, Year)

OCT 19 2012

000 33282

21502

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buttonbush Elkton Ceci Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Month, Day, Year) 221-50-9750 1 **X** M 2 □ F Director Delaware permit. Page 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumetic event, the Marical Exeminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 No Elkton 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Buttonbush 2192 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) atoworke Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Batson Flora Irammel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ElKton MD Trammel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2012 Newark 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 19720 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sonly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final (olun (anax Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physiclan and I for use es the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe I ☐ Yes 1 ☐ Yes 2 ☐ No 2 🔽 To the Hospital or Attending Prystoran: I within 24 hours effer death.

To the Funeral Director: After this certified completely filled in by the funeral director; I 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) MSKLAJAPANEMP 9/28/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MO 21709 NSKajapakremo 2835 Smith 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-07585 State of Maryland / Department of Health and Mental Hygiene Richard Unger 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Time of Death **Medical Examiner** October 6, 2012 1811 hrs Richard Raymond Unger 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meredith Medical Center Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Country) PA Months Days Hours Director 10/12/1963 1_XM 2 F Yrs 189-54-7759 48 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits is 23a or 28a-f show e notified at once. 1 Yes 2 No imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Realth and Mental Hygiene.
ant: If then 27 is marked other than "natural", or items 23a or 28a-f shu me other trannatic event, the Medical Examiner must be notified at once. Monrovia MD Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12198 Overlook Drive 21770 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify:White é 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC-R Representative Sales 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James E. Unger Anna Ventry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. (Son) 504 Edgewood Ave. Coraopolis, Pa. 15108 Unger 20b. Place of Disposition (Name of cemetery, crematory or other place) Itimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: I injury nr othe GrandviewCemetery 10/10/201 Southmont Boro Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licer John Henderson Company Central 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 ✔ No death? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) director, Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 After this 1 Yes No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural 1 Yes 2 No Pending To the Funeral Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **OCME 2006**

completely

Medical

State Registrar

2 🗸 29b. Signature and title of certifie

Jack ∜itus MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

October 7, 2012

Amended #2, nls, per phy., 10/22/12, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 45. [₽]2012 7:55 PMM Nora Valentine Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Allegany Health, Nursing & Rehab Ctr Cumberland 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 M 2 M Aug 26. Director 219-14-7424 87 Usual Residence of Decedent or 28a-f show 10b Count 10a, State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Cumberland Allegany MD 1 Dryes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21502 USA 23 New Hampshire Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 Is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Catherine Evans John W. Burns 1 and 2 should b of Health and Mei item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1015 Kent Avenue Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 Robert Hidey nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or of Davis Memorial Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/20/2012 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or lart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C∈u ∋ (Final disease or c and tion resulting in learn) Pnysician/ ma Medical ue to for as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 ng physician a Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death detached 9 Unknown 9 Unknown P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🗖 No Division of Vital Records. 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the director, page 2 s autopsy performed director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 1 🗌 Yes 2 TNO ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending injury Matural 1 work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year)

State Registrar

r

obustiano

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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> lenna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05:25 M Medical la Facility Name (if not lost tution, give street and numb Examiner County of Death Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 217-12-2495 Director 1 □ M 2 🗓 F 88 March 2,1924 Maryland ir then "naturel", or Iteme 23e or 28e-f ehov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Owings Mills 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Stonemark Court Apt 5 21117 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. \$ 1 Never Married 2 Married altimore, Maryland 21215-0036 filed within 72 hours efter Specify: white 1 ☐ Yes 2X No Specify: 3 ₭ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) cook super thrift Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pege 1 and 2 should be Howard Tosten Florence Guessford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth e Terese Smith - granddaughter 30 Brookshire Drive, Reisterstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Depertment of Importent: If I i eny injury or concess. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October v 2012 Mountain View Cemetety Sharpsburg, Maryland Signature of Funeral Service Lic 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 Pnysician/ se or condition Medical resulting in death) Due to (or a consequence of): [≲]Examiner Sequentially list conditions, Examine if any, leading to immediate cause Finter Underlying Cause (Disease or injury Due to (or and a consequence off: use es the buriei-trensit To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter deeth.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use es the buriel-trensi MUNIC that initiated even Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မှ VIUSPICE 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending iniury Division 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year, 02 cause of death em 23a) (Type, Print) 10 legistrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, pt1perPHYS, G935, 1/4/2013, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month VONDA ANN WATERS 0015 A -2012 10 - 14Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Birthplace (State or Foreign Country) Days (Month, Day, Year) Months Hours Min. 578-90-5802 48 1 🗆 M 2 🕶 F Director 09-21-1964 Yrs DC Usual Residence of Decedent filad within 72 nous accessed Hygiene.

tal Hygiene.

ed other than "natural" or Items 23a or 28a-f show
ed other than "natural" or Items 23a or 28a-f show
event, the Madical Examinat must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD PG BOWIE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15003 PEPPERIDGE DRIVE 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married <u>چ</u> 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BUS OPERATOR WMATA 12TH 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fila and Mantal H Is marked of Department of Health and Mantal Important: If Item 27 Is many Injury or other ည JAMES WALTON VELDA LaGON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWN-TRA FULLINGTON/DAUGHTER 2022 MARYLAND AVE, #200, WASHINGTON, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Donation 5 Other (Specify) CEMETERY 10-23-2012 SUITLAND MD
22. Name and Address of Facility POPE FUNERAL HOMES, P.A. LINCOLN CEMETERY 21. Signature of Funeral Service Lic n 538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician/ disease or condition resulting in death) CHTE AND CHRONIC Medical Due to (or as a consequence of): Examiner STACE IV NON SMALL CELL LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burlal-transit death certificate be axecuted that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ٥ in the past 12 months?
1 Yes 2 No Day signad by the a a
Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, POST OBSTRUCTIVE PNEUMONIA cate has baen sig page 2 should b 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pltal or Attending Physician: The law ours after death. eral Director: Aftar this certificate has tillad in by the funeral director, page 2 s autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 X No ရ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury XNatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral D
completely fillad Hospital cal 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D52503 2012 1511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAILESH SHETH, M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER. 12ªy 201a2 12:10AM WELCH MARY Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO SALISBURY COASTAL HOSPICE AT THE LAKE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Year) 921 FEB. II Months Days Hours 1 M 2 X WASHINGTON, DC **Director** 578-18-9964 91 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No FENWICK ISLAND DELAWARE SUSSEX 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 19944 32 WEST BAYARD ST. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. o 1 Never Married 2 Married Completed by ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NAPIER MAUD **JAMES** FIXX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 32 WEST BAYARD ST., FENWICK ISLAND, DE SANDRA L. WYATT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State DELMAR, DELAWARE CREMATORY OF DELMARVA 10/16/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sig tury HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Fractived Sequentially 11st conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) tal use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be fin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Pregnant at time of death 1 L Yes 2 L 9 D Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? 1 🗆 Yes 2 📈 After this certificate funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 **X**No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury Fall 0700 10/1/12 Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Dire

completed filled in b 32 W Saywalst. Ferwick DE Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar

29b. Signature and

PIME dame and address of person who completed cause of death (Item 23a) (Type, Print)

DO.

100

32. Registrar's Signatur

H5049)

Salsi buy

29d. Date signed (Month, Day, Year)

21801

10/15

12-07957 Andrew Warren V	Voc	Please Type or Print in Bl dmansee State of Maryland						0 0500
	J	- For State Registrar	Certificate		and montain	-	Reg. No.	2 3528
Physician Medical Examin	41/4	1. Decedent's Name (First, Middle,Last) Andrew Warren Woodmansee				2. Date of De Month October		3. Time of Death 0947 hrs
		 Facility Name (if not institution, give street and number) 801 Central Avenue 		4b. City, Town, Davidson	, or Location of Deat	h	4c. County of Dea Anne Arunde	
Funeral			e (In yrs. last birthday)			s. 8. Date of E		irthplace (State or
Director		218-11-5391 1XM 2_F	27	Months D	Days Hours Mir	12/02	/1984 Fore	ign ountry) MD
b	ļ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	nation		1/ 0-	7 = 2 0 1	10d. Inside City Limits
d now any								1 Yes 2 X No
Karyland 28a-f show	Director	MD Calvert 10e. Street and Number	Chesapea	10f. Zip Cod			10g. Citizen of What Co	
3a or 3		3215 Blue Heron Drive S.		20732			USA	
tems 2	uneral	11. Marital Status 1 X Never Married 2 Married Armed Forces?			Hispanic Origin? (S ban, Mexican, Puerto		Io- 14. Race - Ame White, etc.	rican Indian, Black,
fter de	ᄔᅵ	3 Widowed 4 Divorced If Yes, Giva Year	X No	Yes 2X	No specify:		Specify: Whi	t _o
nours a		15. Decedent's Education (Specify only highest grade com	during		pation (Give kind of life. DO NOT use ret		16b. Kind of Business	
36 nin 72 l e. than ",	Completed	Elementary/Secondary (0-12) College (1-4 or \$	5+)				Construct	ion
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	히	17. Father's Name (First, Middle, Last)	Carp	enter	18.Mother's Name	e (First, Middle,	, Maiden Surname)	.1011
d be fillental harked	Be	James Terence Woodmansee 19a. Informant's Name/Relationship (Type, Print)	I dOb Mai	in - Add (0)	Lorrain		Axford umber, City or Town, Stat	7.01
AD 2 2 shoul 1 and N 27 is m	의	James T. Woodmansee, Fathe					esapeake Bch	
re, N. Health		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	20b. Place of Disp	osition (Name of	cemetery,	Date	20c. Location - City o	r Town, State
Pages nent of		4 Donation 5 Other Specify:	Metropol	itan Cre	ematory 10	/24/12	Alexandri	a, VA
Balt Departit. Import		21. Signature of Funeral Service Licensee					ineral Home,	
Physician	+	23a. Part I. Enter the disease, or complications that caused			•		wings, MD 2	Approximate Interval
Wedical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic a	and Alprazo	olam Int	oxication			Between Onset and Death
	- 1	or condition resulting in death) Due to (or as a conse	equence of):					
	틸	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of):					
T it		(Disease or injury that initiated events resulting in death) Last	equence of):					
and and		d. IN UNPENDED AMENDED 23a.	pt.II,27,2	28a-f.pe	r me.2933	11-16-	12 sm	
68760, certificate be nding physicise as the buri		F FEMALE: 23c. If yes, outcome			70		23d. Date of deliver	<u> </u> у
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Juretors. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	3b. Was decedent pregnant in the past 12 months?	time of death	Fetal death Other (Specify)	3 Ectopic pregna	ancy	Month	Day Year
Box e death the atte	Š	1 Yes 2 No 9 Unknown 9 Unknown	ى ت	Other (Specify)				
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attention of the Funeral Director. The funeral director, page 2 should be detached for under director.	고		but not resulting in the	e underlying caus	se given in Part I.		tobacco use contribute to es 2 ✔ No 3 Pro	
ds, equires	Completed by	Hypertrophic Cardiomyopat	<u>iny</u>			24a. Was		utopsy findings available
e law re has to ge 2 sh	Ē					auto perfe 1 ✔ Yes	ormed? death?	completion of cause of
an: The ertification, pa	3 -	25. Was case referred to medical		26.Pla	ace of Death (Check		2 No 1 Y	es 2 No
F Vita	<u> </u>	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatien				ng Home 5		r: Scene
ading J th.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Day,Yo	ear)	1	njury at Work? Yes 2 🗙 No	l	how injury occurred took drug	S
risic r Atter ter dea rirector in by th	Certification:	3 Could not be 28e. Place of Inj	0-12 fd 9: 3 ury - At home, farm, st	reet, factory, offic		28f. Location	(Street and Number or R	ıral Route Number, City
Diving a point of the point of		4 Homicide determined (Specify)	ınd in auto	· 		Davdid	(Street and Number or R State) 801 Cent sonville, MD	rai Ave.
Division To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the	ਲੂ '	(9a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner.						
To T with To com	Med	and manner stated.			ense number		29d. Date signed (Mo	
				0.0	C.M.E.		October 21, 201	2
1001	ļ	0. Name and address of person who completed cause of de	,	10 M/ Pattime	ore Street Palic	more MD o	1223	
Stat	le i	Mary G. Ripple MD. Deputy Chief Medic 11. Date filed (Month, Day, Year) 32. Refistrar			JIE STEET, BAITI	note, MD 2	1223	
Registra	~	A 00 0 4 0040	u B. A	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vanessa Lenore Watkins Month Physician/ 5:47am 10/1 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number g. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 579-94-3071 Director 1 ☐ M 2 F 47 Yrs 05/15/1965 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is merked other then "neturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examinar must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 XYes 2 No Capitol Heights Prince George's MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20743 513 Millwheel Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Administrative Assistant 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sally Jones Charles Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Millwheel St. Capitol Heights, MD 20743 Sally Watkins/mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery: Oct 19,2012 Clinton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Briscoe-Tonic Funeral Home Sembell 2294 Old Washington RD Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Cardial Arrest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physicien and for use es the buriai-transit The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death g Unknown cete hes been signed by the capes 2 should be deteched g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure Records, 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Paranoid Schizophrenia 24a. Was an autopsy performed? Yes 2 X No Peripheral Vascular Disease certificete : After this certifice e funerel director, p To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, **Division of Vital** Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number oct. 12, 2012 D28656

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month De

P.O. Box 68760

Ravi Passi 15245 Shady Grove RD, #130 Rockville, MD 20850

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Oct over Physician/ Charles Junior Warrenfeltz Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hagerstown Washington 14103 Niswander Road 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Nov. 23,1926 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Hours Maryland 220-26-5449 85 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits or Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14103 Niswander Road 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) transportation truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be fil ent of Health and Mental nt: If item 27 is marked y y or other traumatic ev ၉ Martha Regan Carpenter Charles Leroy Warrenfeltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14103 Niswander Rd., Hagerstown, Maryland 21740 Doris Warrenfeltz - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗵 Burial 2 🗆 Cremation 3 🗖 Removal from State permit. Page Department o Important: If any injury or Hagerstown, Maryland 10/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Signature of Euneral Service Licensee MINNICH FUNERAL HOME 22. Name and Address of Facility 21740 415 E. Wilson Blvd., Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ months cerentovascua disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by , MSUlin 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification

State

of person who completed cause of death (Item 23a) (Type, Print) thein

cet

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mary Louise WALTER October 13, 201^{Yea} 12:35am Medical 4a. Facility Name (if not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1097 Marshall Street Hagerstown Washington 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Dec. 10, 72 Maryland 1939 Director 215-34-3781 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director Maryland 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be items 23a Funeral 1097 Marshall Street 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceuc... Armed Forces? . ☐ Yes 2 🖾 No Examiner Black, White, etc. o, 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. life, DO NOT use retired, Elementary/Seconday (0-12) College (1-4 or 5+) dietary kitchen nursing home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic everand Mental F ည George William Demmitt Ellen Louise Ecobona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Miller - son 17821 Timber Lane, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) October Hagerstown, Maryland 4 Donation 5 Other (Specify) Rose Hill Cemetery Minnich Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 BUCa a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ -cars disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin cause. Enter Underlying The law requires that the death cer ificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): ar ending physician at for use as the burial. Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 - Ectopic pregnancy the at er. in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a, Was an Was an autopsy performed? certificate has blirector, page 2 s or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2× No Other: 4 \(\to \) Nursing Home 5 \(\textstyle \) Residence 6 \(\to \) Other (Specify, 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death.

Il Director: After the din by the funera Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined nin 24 hours after the Funeral Dire City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012

Registrar

DHMH 17 Rev 7/2009

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Haperstown,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Moodland orothi 10 Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Waldorf Willow View USA 2604 If Under Hours 9. Birthplace (State of Social Security Number 8. Date of Birth Funeral 1 M 2 X F Months Min. (Month, Day, Year) Nary land Director 220-54-153 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Charles Waldurf 1 ☐ Yes 2 ☐ No Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral Willow lieu 12604 USA 20602 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced Blac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Special 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Ford 19a. Informant's N e/Relationship (Type, Print) 19b. Mailing Address (Street and Null bor or Rural Route Number, City or Town, State, Zip Code) 20602 JAnean a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Department of Important: If it any injury or o ■ Burial 2 Cremation 3 Removal from State 10-18-12 6 🗆 Other (Specify aldor Fineral Service Licenses 20608 th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner + 400 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Line of death
Dregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 1 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 M No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury within 24 hours after deau..

To the Funeral Director: Aft 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) 10023125 10 (11/1) KENILWORTH AUT RIVERDACE MOZO737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6502 MOLLAN 31. Date filed (Month) Registrar's Signatu

PHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

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State of Maryland / Department of Health and Mental Hygiene	2010	0 0 0 0 0 0
Certificate of Death	De- No 2012	35295

		1- For State Registrar			rtificate o		ina mene	arriygiche	Reg. No.	2012	3529
Physic Medical Exam		1. Decedent's Name (First, Middle Ronny D. Yee		le Y	ee			2. Date of De Month October	ath Day	Voar	3. Time of Death
		4a. Facility Name (if not institution Anne Arundel Medical				4b. City, Town, Annapolis			40	c. County of Death Anne Arundel	
Funera Director		215-58-9539	5. Sex 7. Age	(In yrs. la	ast birthday) Yrs		ear If Under ays Hours	24Hrs. 8. Date of B Min. 07/07		/DD/YYYY) 9. Bir Foreig Co	
Maryland 28a-f show any 1 at once.	ō	Usual Residence of Decedent 10a. State 10b. County MD Anne A		10c. City,	Town or Local	tion Crof	ton				10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Il Director	10e. Street and Number 1642 New Windso	r Court			10f. Zip Code	21114		1	izen of What Coul	ntry?
fter death w ", or items er must be	by Funeral		1 Yes 2 .	X _{No}	S. 13 Wa	as Decedent of Yes, specify Cub	an, Mexican, I	n? (Specify Yes or Ni Puerto Rican, etc)		14. Race - Ameri White, etc. Specify: Whi	can Indian, Black,
2 Z E	ompleted	15. Decedent's Education (Speci Elementary/Secondary (0-12) 12	y only highest grade comp College (1-4 or 5-		during m	nt's Usual Occup nost of working I	oation (Give ki ife. DO NOT u	nd of work done ise retired)		Kind of Business/I	•
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than imatic event, the Medica	o Be Co	17. Father's Name (First, Middle, L Harry Yee 19a. Informant's Name/Relationshi					Doro	Name (First, Middle, thy Fitzge	Maiden eral	Surname)	<u> </u>
, MD 2 und 2 shoul salth and N em 27 is m	ĭ	Geraldine Yee 20a. Method of Disposition	p (Type, Print)	Took 6	1642	New Win	dsor C	er or Rural Route Nu t.,Croftor	ı, M	D 21114	
Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		1 Burial 2 X Cremation 4 Donation 5 Other Spe	cify:	C	rematory or oth tro Cre	ematory		Date 10/6/2012	Ва		
		21. Signature of Funeral Service L			65	12 NW C	rain H	Beall Fur wy., Bow	rie,	MD 207	15
Physician /Medical Examiner	U	23a Part I. Enter the assesse, or distinct. List only one cause of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the each line. a Narcotic (1) Due to (or as a consection)	lorpl	nine) I			diac or respiratory arr	est, sho	ock, or heart	Approximate Interval Between Onset and Death
	Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequence)				-				
red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
760, ficate be executed g physician and the burial - transi	Medical	X UNPENDED	x AMENDED #1,2	3a,2	7,28a-	f,per m	e,g933	11-8-12 s	m		
	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	23c. If yes, outcome 1 Live birth 4 Pregnant at til		2 Fet	tal death 3	Ectopic p	pregnancy	- 1	d. Date of delivery Month D	ay Year
P.O. Ess that the canada by the detached	by Phy	Part II. Other significant condition	9 Unknown	out not re	sulting in the u	nderiying cause	given in Part	I. 23e Did to			he cause of death?
cords law requ has been	Completed			-				24a. Was autop	an sy med?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
	Be	25. Was case referred to medical examiner?	Hospital: 1 Innational	0.54			Other:	heck only one)			8 2 No
	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury (Month, Day, Yea		ER/Outpatient 28b. Time of Ir		ury at Work?	lursing Home 5 28d. Describe l	Resider		
Division tal or Attendi	icatio	1 Natural 5 Pendin 2 Accident Investig	51 10 2	12	fd 13:2	. ОРЩ	Yes 2 x N				
Division To the Hospital or Attent within 24 hours after death To the Faneral Director:	Certification:	3 Suicide 6 X Could r 4 Homicide determi	ned (Specify) Re	eside	ence			Crofton	, MD	•	al Route Number City Vindsor Ct.
To the Hospita within 24 hours To the Funeral completely fille	edica	(Check only one) 2 Medical Exami	ician: To the best of my k ner:On the basis of examir and manner stated	nowledge nation and	e, death occurr d/or investigati	on, in my opinio	n, death occur	e, and due to the caus	e(s) and and plac	d manner as stated be, and due to the	d. cause(s)
M		29b Signature and title of certifier					se number .M.E.		_	bate signed (Moni	th, Day, Year)
1		30. Name and address of person wh Ana Rubio M.D., Ph. D.	o completed cause of dea Assistant Medica			W. Baltimor	e Street, B	altimore, MD 21	223	<u>.</u>	
St Regist	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signatur	barke	,					

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23:28 M ELAINE ALPERT Octobe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital 04 Baltimore Bailtimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Min. Country) Director 220-22-3588 1 M 2 XF 10/06/1929 MD 83 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 BEDFORD AVENUE, APT. 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed ELAINE Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) HEALTHCARE ADMINISTRATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ COHEN ANNA SCHINDLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12412 KNOLLCREST ROAD, REISTERSTOWN, MD JODY STEIN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MOSES MONTEFIORE WOODMOOR HEBREW 1 Burial 2 Cremation 3 Removal from State 11/02/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa r of Funeral Service Live ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrica Intracranial 7 das disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypert ension Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months? Month Day Year ed by the at edetached for Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Hyper lipidenia Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30,2013 000 M.D. October RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. BELVEDERE SINAL HOSPITAL OF BALTIMORE KATRINA ABADIWA, M.D. 31. Date filed (Month, Day, Year) State NOV 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 0 2012 Mary Elaine Allen 1:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) **Director** 216-18-3826 1 🗆 M 2 🗶 F 90 9/19/1922 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 No Maryland | Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 109 Forest Valley Drive U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with... -tal Hygiene. -r than "r (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygien 12 Sales Dept. Store Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Bertha Koehl William G. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Wayne F. Allen / son 1400 Overlook Way Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 11/5/2012 Timonium, Maryland 21. Sign Forneral 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final nollmomo Physician/ disease or condition resulting in death) Medical Due to der as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran 8201 Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending e Hospital or Attending 24 hours after death. e Funeral Director: Afte 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DOO 63220 0 20/2 10/ GEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 31. Date filed (Month, Day, Year) Registrar's Signature State 5 NOV 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ime of De Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 212-98-1076 Hours Director 1 M 2 X F 11/24/66 45 Yrs Ohio Usual Residence of Decedent or 28a-f shov the Maryland th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 1217 W. Fayette Street 21223 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Food Service 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Michael Cornecelli Linda Brammer 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alecia N. Beatty (Daughter Searles Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any Injury or oth Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Hilltop Service Corp 11/02/2012 Towson, Maryland 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. SOC . Scott P. Gardner 7922 Wise Avenue Dundalk Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ enkemia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injustrat initiated events resulting in death) Last Due to (or as a consequence of): **burial-**1 signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12,months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown been signated should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) (1) PA har-1 Yes 2 00 မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Thurmand mule Da7683 10/27/12 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1525 Mills OWINGS Kaymord 21117 31. Date fled (Month, Day, Year) State 5 20 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month KAREN ANNE BENNY 2012 10 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death COLUMBIA GILCHRIST HOSPICE HOWARD . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5/25/1952 Hours 1 M 2 X F 215-56-4501 60 MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits CARROLL MT. AIRY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1505 SEARCHLIGHT WAY 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL PRINCIPAL EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KATHERINE SULLIVAN JOE LAYTON KOONTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRIE BREEN - DAUGHTER 1505 SEARCHLIGHT WAY, MT. AIRY, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 25 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 11/2/12 GLEN BURNIE, MD 21. Signature of Filmaral S 22. Name and Address of Facility SKARDA FUNERAL HOME MO1120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE MD 21224 Approximate Interval Between Immediate Cause (Final Onset and Death Cancer Brease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 4 Pregnant at time of death Month Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 N 1 Yes 2 🗆 No 26. Place of Death (Check only one) Hospital:

physiclen end s the burial-trensit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 use as ettending p certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/

Medical

10a. State

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Funeral

Director

should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked other than "netural", or Items 23a or 28a-f sho 's marked other than "netural", or Items 20 or 28a-f sho 'aumatic event, The Medical Eventher must be notified at

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permit. Page 1 a
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any Injury or ot

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Certificate:

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Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical 1 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 1 🛛 Natural iniury 5 Pending Investigation Accident

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospue 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature a rd title offcertifier 29c. License number 29d. Date signed (Month, Day, Year) D72139 2012 whan MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 HBBAS MD YED EDAR

OLUMBIA

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ Keri Lynn Bennett 6:10 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia Gilcrest Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220 72 9400 Director 1 □ M 2 🗓 F 35 12/13/1976 Maryland 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene.
item 27 is marked other then "natural", or Items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6461 Bright Plume U.S.A. 21044 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 🕅 Never Married 2 🗆 Married 1 ☐ Yes 2 🕅 No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fred Bennett Laura Szuchnicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Chowdhry / Mother 6461 Bright Plume Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Depertment of Importent: If it eny injury or o ₹ 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2012 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lie 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANOXIC encephalo disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CArdiAc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for use as the burlel-transit Division of Vital Records, P.O. Box 68760 Cause (Disease or injury After this certificate has been signed by the ettending physician end funeral director, page 2 should be detached for use as the burlel-trar that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မူ pice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fune 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 025205 October 29,2012

State Registrar 31. Date filed (Month, Day, Year)

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N. Charles St. Balto Md 2120x

cause of death (Item 23a) (Type, Print)

GBMC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 150 PM Physician/ 3 201 Medical County of Death Town, or Location of Death Examiner twine If Under 8. Date of Birth 9 Birthplace (State or For On vrs last hirthday **Funeral** (Month, Day Country) Hours Min Year) Director 219-28-2694 1 DM 2 □ F MD Aug. **09** 1933 Usual Residence of Decede permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be accessed</u>. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 111 Kent Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Chief Petty Officer US Navv 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Loretta Weinbrenner Frederick **Brokos** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 111 Kent Road, Glen Burnie, <u>Patricia Brokos</u> MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Nov Date 03 20c. Location - City or Town, State Metro Crematory or other p 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 20N To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Hipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rosedale 4824 Ridge Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** N/A 1 □ M 2 💢 F 09 12 64 48 Pakistan 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits Director 1 XYes 2 No Rosedale NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pakistan 21237 4824 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Asian Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Unemployed Unemployed na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mohmmed Ashraf Zohara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4824 Ridge Road, Rosedale, Md 21237 Akhtar Bashir-Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State King Memorial Park 10/25/12 Woodlawn, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave Balto, Md 21215 1-806 Jarch 4h (aham 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician thyroid cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Completed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 N 2 🗌 No Yes 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 🗖 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier MSRyapalmeno 29d. Date signed (Month, Day, Year) DODS 7465 10/25/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSROJAPAKSOMO Baltimore MO 2835 Smith AV 5703

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:00 A M Physician/ Bach 2012 Carl Frederick October 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 619 Fairway Drive Towson If Under 1 Year If Under 24 Hrs, 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Davs Hours Min. (Month, Day, Year) 215-30-9652 80 Director 1 X M 2 □ F Maryland 1932 Aug. 19, 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 K No Towson MD. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number **USA** 21286 619 Fairway Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. by 1 Mever Married 2 ☐ Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Insurance Accountant 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ္ Bertha Volkman William F. Bach eq pinous 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau once. 8115 Pleasant Plains Rd. Towson, MD. 21286 Renee Brown/ Niece Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 11-2-12 Towson, Md. Service Co 4 Donation 5 Other (Specify) k Towson Funeral Home, O York Rd. Towson, Md Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause or DAYS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the at id be detached fo 9 Unknown P.O. death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant Completed by 1 🗌 Yes 3 Probably 4 Unknown Records, cate has been signated by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No this certificate Yes 2 To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director in 26. Place of Death (Check only one) 25. Was case referred to **Division of Vital** Be Other: 1 🗆 Y 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) ₽ 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 ☐ Pending Investigation 6 ☐ Could not be 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 22645 2013 p who completed cause of death (Item 23a) (Type, Print) 1734 YORKRA LUTHERVILLE IMD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Ellis Blackwell 2030 PM October Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore Sincu 2 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 217-22-7421 08/28/1929 Country) Director 1 XM 2 □ F 83 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director FLFlagler Palm Coast 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 230 Parkview Drive 32164 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1 0 4 9 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates. 1948-49 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement Baltimore City Police 2vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unk Gladys Blackwell 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9145 East Stayman Drive Ellicott City MD Jacalyn Blackwell-White 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 11/02/12 Glen Burnie MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ome ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

3 months Immediate Cause (Final Physician/ with complications disease or condition Medical resulting in death) Due to (or as a considerace of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last the Hospitai or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nd stage renal disease 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown idoletes Meditus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate rtension 2 No 1 Tes director, Be Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ After this Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) . Manner of Death

1 Natural

2 Accident

3 Suicide 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License numbe 30,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Youssel Sirai

State

Registrar

filed (Month, Day, Year)

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32. Registrar's Signature

John	William	Bernard	

State of Maryland / Department of Health and Mential Hygiene **Per Bulbs Contributed of Death Son No. 2 0 2 3 3 3 3 ms Contributed of Death Son No. 2 0 2 3 3 3 ms Contributed State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State of State of Contributed State	12-07922 John William E	ern:	Ple	ease Ty	pe or Print i	n Black li	ndelible	Ink. Ens	ure All	Copies	Are Le	egible.		
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Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			anes	2	·			0.0	.M.E.					
State 31. Date filed (Month Day Year) 32. Registrar's Signature						•	,	W. Baltimor	e Street	, Baltimor	e, MD 21:	223		
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1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cete has been sig ; page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificete funeral director, pag 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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Registrar
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Medical HICOMICO CLA 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 78-7182 Days Country) Director 1 XM 2 □ F 7-5-1964 of Haalth and Mental Hyglene. Item 27 is markad other then "neture!", or iteme 23e or 28a-f ehow other treumetic avant, the Medical Evantal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 Jeci 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes. Give Specify: Black 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Haalth and Me of Haalth and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Baltimor ores e. MD Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Information of Inf Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility E. North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metachalin disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burlai-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 🗀 No Yes 2 No 1 🗌 Yes To the Hospitel or Attending Physicien: "within 24 hours after death.
To tha Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) examiner? Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred J∕☐ Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 163 155 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Frank Lee Coles 4:52 AM NOVEMBER Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSBITAL OF BAUCIMORE BALTIMORE CITY N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Country) 212-42-9560 Director 1**X** M 2 □ F 68 Yrs. 12/03/1944 New Jersey i Hygiene. other than "naturel", or iteme 23a or 28e-f aho vent, the Medical Exeminar must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Directo Randallstown Baltimore MD 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9928 Hoyt Circle 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed 5+ Master Electrician Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked c Mary Martha Williams Frank Lee Coles, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health (Johnetta Coles (Wife) 9928 Hoyt Cir. Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 21. Signature of Funeral Service License ^{22.} Joseph H Facili Brown Jr. Funeral Home PA Balto., MD 21217 2140 N. Fulton Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, where failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEVERE METABOLIC ACIDOSIS DAYS Medical Due to (or as a consequence of): Examiner ACUTE ON CHADMC CENAL FAILURE Sequentially list conditions. Examine If any leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown HUDECTENSION, DIAPPERS MELLIUS 14PE 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending М 1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

• Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
• Funeral Director: After this certificate has been eigned by the attending physician and letely filliad in by the funeral director, page 2 should be detached for use as the burial-transit or Attending To the Hoap within 24 ho To the Funa completely f

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31. Date filed (Month, Day, Year) State NOV 0 5 2012 Registrar

29a, Certifier

only one) 29b. Signature and fittle of certifier

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ASHRIT MUDIANI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINA AOSPITAL OF BALTIMONE

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2 | Medical Examiner: On the basis of ray knowledge, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

NOVEMBER Z, ZUIZ

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 35309 Adam Cockey 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 30, 2012 1338 hrs Medical Examiner Cockey, Jr. Adam D. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Gilchrist Hospice Columbia If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days country)Maryland 05/08/1941 Director 71 213-36-6542 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Cockeysville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21030 U.S.A. 10531 Willow Vista Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes White Specify: 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked nither than "nat
injury are nither traumatic event, the Medical Exa Completed College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Realtor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Cockey, <u>Dorothv</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10531 Willow Vista Way, Cockeysville, MD 21030 Dolores T. Cockey-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/03/12 Timonium, MD Dulaney Valley Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. William G. Dau Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Fall Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and sician/Medical #1 Per ME G933 11/06/2012 JH UNPENDED X AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Yea Fetal death Month Day Live birth 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 9 Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown <u>6</u> Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 🗸 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject fell Oct 17, 2012 1 Natural 2315 hrs 1 Yes 2 ✔ No death. d in by the f 5 Pending 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after d

To the Funeral Direc

completely filled in by Could not be Suicide or Town, State) 5220 Marriott Drive, Pheonix, AZ (Specify) Local Street determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 31, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Ana Rubio M.D., Ph. D.

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

ORIGINAL

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per 1NF, g933 11-8-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Arnold Wayne Crump 2012 2130 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) (Month, Day, Year) Director 1 XM 2 □ F 88 12/23/1923 New York Usual Residence of Decedent irel", or items 23e or 28e-f show Examinar must be mutified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director Maruland Montgomery Wheaton 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2703 Dawson Avenue 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

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Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month יט עום runerer urrector. After this certificate has been signed by ז completely filled in by the funeral director, pege 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Chronic Obstructive Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 \lambda No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 2 ᠺ No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation s after deat 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours at Funerel D Medical 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) CMahos D0068681 October 25. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 M.D., Charu Maheshwary, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 30 Physician/ 2012 1:40am Helen Carnvale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Rockville Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) **Funeral** Hours Min. Director 191-03-0109 1 🗆 M 2 🗴 F Yrs. 93 09/23/1919 Pennsulvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Rockville 1 X Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 20850 303 Adclare Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathryn Barchuk Frank Sebosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Feather Rock Drive, Rockville, Maryland 20850 Marlene Baker - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Crematory 11/06/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licenses M01621 owa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease arkinsons Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed To the Hospital or Attending Physicien: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10/31/2012 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, MD 20850 DR. SHARMA 9701 VEIRS

State Registrar 31. Date filed (Month, Day, Year) NOV 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F tificate of I			ene 2012	35313
2			Decedent's Name (First, Middle, Las	1)				2 Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		Albert Samuel Co	ok, Jr.				October	30 2017	
)	Examin	_	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	th
			Keswick Multi-Ca		(l l	Baltimo	re If Under 24 Hrs.	0 Date of Birth	N/A	theless /State or Fernian
	Funeral Director		213 20 0323	x 7. Age	(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, 3/24/192	Year) S. C. 21 Mar	thplace (State or Foreign ountry) yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary	ţō	Maryland Baltimor	e	Luthervil:	le				1 ☐ Yes 2√☐ No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	ountry?
	h with	Funeral Director	21 Seminary Farm	Road		210	93	Ţ	U.S.A.	
	deal	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Ie marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1⊡Yes 2∏XNo	Specify:		Specify: W	hite
5-0	72 h	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kind of Business	s/Industry
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5 5+	+)	orney	2)		Law	
d 2	other i	e Co	17. Father's Name (First, Middle, Last)	ЭТ			18. Mother's Name	First, Middle, M	Maiden Sumame)	
an	Aental Aental rked o	മ	Albert Samuel Cook				Helen Ea	ırnshaw		
ary.	2 should and Men le marke sumatic	F	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Run	al Route Number	, City or Town, State,	Zip Code)
	and 2 ealth a n 27 le		Bernice Ann Cook	/ wife	21 S	eminary F	arm Road	Luther	ville, MD	21093
J.e.	of Heal		20a. Method of Disposition		20b. Place of Dispo		ce)	Date	20c. Location - City o	r Town, State
Ē	Pages nent of ant: If It ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Hilltop		-		Towson, Ma	
Baltimore,	permit. Pages Department of I Important: If Ite eny Injury or of		21. Signature of Funeral Service Licen	Meli	22	2. Name and Addre	ss of Facility Ruc Road Tov	k Towson vson, Ma	n Funeral ryland 212	Home, Inc. 04
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Hunon		Nyionusca	dy dis	PLOS		Onset and Death
	/Medical		resulting in death)	Due to for as	a consequence of):	-				
	Examiner	_	Sequentially list conditions,	b. Dem	entra					
	be tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
•	and and II-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
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687	ficate g phy: as the	edicai		d						
.O. Box	The law requires that the death certificate has been signed by the attending for age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
<u>a</u>	that the ed by detac		Part II. Other significant conditions o	ontributing to death b	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
sp.	uires I sign	d by	Right Bundle	Branck b	lock			1 🗆 Y	es 217No 3⊡1	Probably 4 Unknown
of Vital Records,	w requ	Completed						24a. Wasa		autopsy findings available
Re	The lav	mo						autops perfor	med# death?	completion of cause of
ital		0	25. Was case referred to medical				26. Place of Deal			
₹ 	g is	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA Ott	ner: 42 Nursing Ho	ome 5 🗆 Reside	ence 6 □Other (Sp	ecify)
	ding Pt h. After th funeral		27. Manufer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	Wo		28d. Describe h	ow injury occurred	
Sio	ottendin death. ctor: A y the fu	catio	2 ☐ Accident investigation	1			Yes 2 □ No	201 1 11 12		2 -12 - 14
Division	or fiter Dire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		City or Tow	treet and Number or i n, State)	nural moute rumber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and mamner sta	of my knowledge, deal f examination and/or in ated.	th occurred at the ti	me, date and place, opinion, death occur	and due to the c red at the time, o	ause(s) and manner date and place, and di	as stated. ue to the cause(s)
t.	vithin 2 Vithin 2 To the	Me	29b. Signature and title of certifier	2/12			se number		29d. Date signed (Mo	nth, Day, Year)
			N LOSPA	MD		Do	064788	1	October 3	0 2012
11			30. Name and address of person who	completed cause of d	leath (Item 23a) (Type 21 N. EUTA	Print) PW 2T.	SUITE 30	I BAC	TIMORE MI	21201
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	arkel				
				- · · · · · · · · · · · · · · · · · · ·	- AT 17					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35314 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 4:26 A_M November Anne F. Dean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 216-18-4661 1 □ M 2 🗓 F **Director** Yrs Maryland July 8, 1924 88 Usual Residence of Decedent show 10d. Inside City Limits r 28a-f shorn 10a, State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 8800 Walther Blvd. #1616 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Black. White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: white 3 x Widowed 4 □ Divorced Completed Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Accounting Accountant permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph F. Soler Rose M. Kaspar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nephew 4026 Holly Knoll Drive; Glen Arm, MD 21057 David C. Page 20a. Method of Disposition 1 Deurial 2 Crer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 - Removal from State Department of Important: If any injury or once. 4 Donation 5 D Other (Specify Hilltop Service Corp!11/5/2012 Towson, MD Signature of Funer-I Service Lic 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiomyorathi disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 🔲 Yes 2 🕡 Ko for Dav Year Pregnant at time of death 5 Other (specify) be detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 1 Yes 2 No Yes 2 1 No Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Descritifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a)

DHMH 17 Rev 06-2011

/X

State Registrar

ORIGINAL

12-08204 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Anthony Arnold Diggs 1- For State Certificate of Death Registrar 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day October 30, 2012 0808 hrs Medical Examiner Anthony Hrnold 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Western Maryland Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Director 12/16/1982 Country) MD 220-17-4001 1 X M 2 F 10c. City, Town or Location 10d. Inside City Limits ij 1 Yes 2 No MD Baltimore or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other reaumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number USA 614 Turnbridge 21212 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 1 Yes Specify: Black Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed ð 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SuperFRESH Baltimore, MD 21215-0036 Clerk 18. Mother's Name (First, Middle, Maiden Surname) Tames Arnold Delores Dutton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 604 Turnbridge Rd · BALTO, MO · 21212

pa of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Jamie CHEW 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BALTIMOTE, Md PARKWOOD Cemetery 4 Donation 5 Other Specify. 21. Signature of Funeral Strvice Licensee Road. BALTIMORE, MD. 21212 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** 'Medical Death a. Complications of Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other: examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) Mar 17, 2001 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject shot 1 Natural 1700 hrs 1 Yes 2 ✔ No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Lakewood & Monument Street, Baltimore, MD (Specify) Local Street within 24 hours a To the Funeral determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 1, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ N**owember** 2019 ar Robert Lee Davis 1348 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign MD (untry) Days 218-44-6385 Months Hours Min 01/23/1947 Director 1 **∑** M 2 □ F 65 Usual Residence of Deceder ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore n/a MO 1 XYes 2 No 10f. Zip Code 21225 10g Citizen of What Country? 10e. Street and Number 901 Cherry Hill Road Apartment #264 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If 4es, Give Year or Dates. 1952–64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. 7 is marked other than "r 12 Elementary/Secondary (0-12) College (1-4 or 5+) Steel Manufacturing Truck Driver æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked (ဂ္ Lee Davis Jennie Florence High 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashawn Davis-Barber / Daughter 1638 Ashland Ave Baltimore, MD 21205 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 🔲 Burial 2 🂢 Cremation 3 🗖 Removal from State Cremation Ctr of MD 11.8.2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Schature of Funeral Jorgan Joun L. Williams Funeral Directors, P.A. 4517 Park Hghts Ave Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Ohset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or is a consequence of): Examiner Sequentially list conditions, 1.48pm if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): nding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No

9 Unknown 3 Ectopic pregnancy for Day Pregnant at time of death 5 Other (specify) signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by embol 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) PICE 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: ne Hospital or Attending P n 24 hours after death. Ie Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Understand injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D185 VOV 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) Gormby 838 N. Eutaw Street Baltimore, MD 21201 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Patricia Emery 1318 M 2012 Medical 10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 004-32-9811 Director 77 1 □ M 2 🕱 F Maine 03/29/1935 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Mechanic Falls Maine Androscoggin 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 7 Lower Myrtle Street 04256 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evea any injury or other traumatic evea onee. ٥ Elora Hutchinson Edward Dolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 980 College Drive Arnold, Maryland 21012 Cary Emery Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

GracelandMemorialPark 10/26/2012 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Auburn, Maine 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, 6009 Harford Road Baltimore, Maryland 21214 masulle 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 1 day disease or condition resulting in death) Acrtic Rupture Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 09289 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Year Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s performe Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ٥ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 06-2011

State

Registrar

ricall hern

NOV 0 5 2012

Michelle Kerns

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZZ South GREENE STREET

1821388976

Bathmore, MD 2120

10/20/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30.per DVR.g933 11-5-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NEST 20:35 PM HOVEMBE Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHN HOPKINS BAYVIEW **BALTIMORE** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Davs Hours 05-29-1945 Director 218-42-1796 MD 67 Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD BALTIMORE TURNER STATION 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 CHESTNUT STREET 21222 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. Completed by 1 Never Married 2X Married 1 Yes 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 1965-67 BLACK or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BETH STEEL 12 PAINTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental Fitem 27 is marked o ည LUCY A. COLE SAMUEL EVANS, SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 CHESTNUT ST., BALTO., MD 21222 LAWANA BEVERLY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State HOLLY HILLMEMEM 11-7-2012 MIDDLE RIVER, MD Donation 5 Other (Specify) 21 (Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC 22. Name and Address of Facility formes Ch. 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death SEPSI'S Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) CARCINOMA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 N After this certificate 2 No 1 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death filled in by the сопретер the within 2

Medical

31. Date filed (Month, Day, Year) State 5 2012 Registrar

29a. Certifier

(Check

only one)

3 🗆

29b. Signature and title of certifie

30. Name and address of pers

4940 Eastern Ave. AlEast STe: A-150 Baltimore, MD, 21224

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

NOVEHBER 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 per med cert G93/ 3/4/13 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Elizabeth H. Eckenrode 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Pickersgill Assisted Living Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min. Mary Land /87494g 220-48-1028 93 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 615 Chestnut Ave. #1202 21204 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Edward Gale Hooper Julia Egerton Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau Alice Alkire / daughter 20283 Doswell Place Ashburn, VA 20147 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State Hilltop Serv. Corp. 10/29/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ONGESTIVE Due to or a Consecutive Immediate Cause (Final Onset and Death ≠nysician/ disease or condition resulting in death) DARS Medical Examiner OBSTR HRONIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown ts been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the pause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed Yes 2 certificate 1 🗌 Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spec 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Registrar

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Year 5

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 37 OCCU 2012 10:34 P M William Thomas Engel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min. 219-50-6922 1 M 2 □ F 62 **Director** Marvland May 4, 1950 Usual Residence of Decedent il Hygiene. I other then "nature!", or items 23a or 28a-f show vent, the Medical Evaminer must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral USA 21222 3503 Dunhaven Road within 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1970—1973 Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Greif Brothers Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file. I and Mental H 0 Irene T. Thompson permit. Page 1 and 2 should be Department of Health and Ment Importent: If item 27 is marker eny injury or other traumatic e William H. Engel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 Dunhaven Road Dundalk, MD 21222 Margaret Jean Engel Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hilltop Service Corp. Nov 1, 2012 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Fund al Service Limited 22. Name and Address of Facilit Duda-Ruck Funeral Home Of Dundalk, Inc. 7922 Wise Avenue Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MRSA Physician/ ens disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physicien: The law requires that the death certificete be executed thin 24 hours after death.

the Lake Abous after death.

the Funeral Director. After this certificate has been signed by the attending physician and the Funeral Director. After this certificate by the detached for use as the burlal-transit mopletely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 X Unknown Completed I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS PLO 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complex only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 641 TOWSON MO SAMA MIES 701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 12:12 PM **Physician** Clarence October Gaton 0012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Citv Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Numbe 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 216-24-7208 March 28,1928 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show a notified at 1 ☐ Yes 2 X No MD Baltimore Director Dundalk 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö pe 1706 Evergreen Drive 21222 United States must ! Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? N□Yes 2□No If Yes, Give Year or Dates:Mar 1946-1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2x No Specify: White ģ 3v Widowed 4 □ Divorced "natural" Completed 1946. Decedent's Usual Occupation 16b. Kind of Business/Industry May 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) the M College (1-4 or 5+) Elementary/Secondary (0-12) al Hygiene. N/A Steel 11 years Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Clarence Lehigh Eaton Helen Grace Gatewood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen Zamenski (daughter) 1706 Evergreen Drive, Baltimore, MD 21222 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If ite
any injury or ot 1 Burial 3 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Nov. 2,2012 Baltimore, MD 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, MD 21222 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician rest 10 Minutes ARDIAC /Medical Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ue to for as a consequence of or Attending Physician; The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Live birth 2 Fetal death Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 2 No 3 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes Νo 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence Hospital: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 🗆 DOA 6 Other (Specify) မ Manner of eath Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Injury Natural 2 🗌 No 1 Yes Director: Af 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Name and address of person who completed cause of death (Item 23a) (Type, Print) t sates

and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) 5

29b. Signature and title of cer

Registrar

State of Maryland P Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month teather. 10:50 0 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWSON Himore ente If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 8-842 (Month, Day, 89 1923 1 **X** M 2 □ F Director or 28a-f show 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 2/2/3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: and Mental Hygiene. Is marked other than "natural", Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

Postal Carrier (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) sta 1,2th permit. Page 1 and 2 should be filed w Degartment of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည ones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Featherstone Jr. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Garrison 2012 DWINGSMIlls 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 0 Ba Ave. 21202 mette 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 1000 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 ☐ No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my calculated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOCUST 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Lucille Vivian Foster 2012 5:30 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14601 Good Hope Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 218-30-4262 **Director** 1 □ M 2 🛚 F 99 10/21/1913 Washington, DC 2 should be filed within 72 hours after death with the Maryland the end Mental Hygiene.
27 is marked other than "neture!", or items 23a or 28e-f show treumatic event, I'm Madical Evainings must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 14601 Good Hope Road 20905 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify African-American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Engineer House Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Carroll. Sr. Margaret Sommerville and 2 should b Heelth end Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Powell - Daughter 1111 Larchmont Avenue, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2012 Silver Spring. MD Gate of Heaven Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Failure To Thrive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Generalized Debilitation Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: or Attending Physicien: The law requires that the death certificate be executed burial-transit Vascular Collapse Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 the attending physician hed for use es the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown ☐ Ectopic pregnancy 5 Other (specify) Pregnant at time of death cate has been signed by the in page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number gue October 25, 2012 D29353

Registrar
DHMH 17 Rev 06-2011

5530 Wisconsin Avenue, #1400, Chevy Chase, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Graves, M.D., 5530 Wisconsin A

32. Registrar's Signature

George Graves,

NOV 0 5 2012

12-08196	
Wanda Foster	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vanda Foster	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2 1 2 3 5 3 2
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1700 brs
redical Examine	Wanda Foster October 29, 2012 1766 113 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	648 Bartlett Avenue Baltimore N/A
Funeral Director	5. Social Security Number 219-62-1106 6. Sex 1 Months Days Hours Min. 2 F F F F F F F F F F F F F F F F F F F
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Aaryland 28a-f show Lat once. ector	MD N/A Baltimore 1 X Yes 2 No
the N a or ciffee	
r death with , or items 23 r must be no	11. Marital Status 1 Never Married 2 Married 2 Married 2 No Second Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No No No Never Married 2 Married 14. Race - American Indian, Black, White, etc.
after d	
5-0036 ed within 72 hours afth tygiene. other than "natural" the Medirel Ex smine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
onthin 7 ene.	GED N/A Truck Driver Warehouse Co.
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medir	
212 ould be d Menti s mark fic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD nd 2 sho alith and m 27 is	La-Kia Davis-Daughter 6103 Bellona Ave. Apt.1A Balto.MD 21212 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State crematory or other place)
altim nit. Pa partmen sortand	4 Donation 5 Other Specify: Mt. Zion Cemetery 11/7/12 Lansdown, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility March F/H-East
	1101 E. North Ave. Baltimore, MD 21202
Physician /Medical	23a. Part I. Phier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
Solution Insit	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):
ated and ransit	events resulting in death) Last Due to (or as a consequence or). d.
so, te be executed yisician and burial - transit	UNPENDED AMENDED
8760 tificate b ng physi as the bu	
Records, P.O. Box 6876: The law requires that the death certifical fifcate has been signed by the attending ph. r, page 2 should be detached for use as the Completed by Physician///	past 12 months? 4 Pregnant at time of death of Unknown 9 Unknown
O. B. it the de lached i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
s, P.O. ires that the signed by dispersed by F.	Thyroid Disease 1 Yes 2 No 3 Probably 4 V Unknown
ords aw requas beer 2 should	24a. Was an autopsy findings available autopsy prior to completion of cause of
Rec The l ficate h	1 Yes 2 No 1 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one)
/ital /sician /sician is certi	examiner? Hospital: The spiral of the spiral
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be entification: To Be Completed	27. Manner of Death 1 Natural 5 People 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Sion Attend r death. ector: by the f	Natural 5 Pending Investigation 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divi italor, its after rat Dir lfed in	3 Suicide 6 Could not be determined Homicide Could not be determined (Specify)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical Elements	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To th within To th comp	2 wedland Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and do to the occupy and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. October 30, 2012
7	30. Name and address of person who completed cause of death (Item 23a)
State	Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Mon Nov Or) 5 2012 32. Begistrar's Signature
Registra	NOV 0 5 2012 Jenus S. Jackel

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amend #30, per dvr, g933 11-5-12 sm
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 2 Medical Kathleen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anno Arnod BURNIE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 1 M 2 X F 89 215-16-6048 Nov. 23,1922 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 634 Drive 21122 Drain USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Helbling Fint Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 Supervisor US Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Newell Catherine Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Indian Creek Lane, Kathleen Kalivoda (daughter) Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. Nov. 3, 2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, PA 21. Signature of Funeral Service Lide <u>3111 Mountain Rd., Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Managento 55 4AAA Medical resulting in death) Due to (or as a consequence of). 11 dos Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. nding physician and use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) -2-12 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Dr. Glen Burnie, MD, 21061 31. Date filed (Month, Day State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 35326 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:28 $\rho_{\rm M}$ Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Social Security Number last birthday) 9. Birthplace (State or Foreign **Funeral** Director show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ral", or items 23a or 28a-f s Examiner must be notified timore 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ and I 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No Health a Himore MD 21202 Baltimore, Place of Disposition (Name of Department of Important: If it any injury or or cemetery, crematory or other place Owinas Mills, A 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fulleral Service Licensee imore, MD 21202 Jor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ arynaeo disease or condition resulting in death) Medical Due to (or as a conse we nce of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be signed by the attending phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has performe 2 No 1 Ves Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital Other: ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 【 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conflicting Number Practicular: To the best of my knowledge death occurred at the firme calls and place, and the representation of the cause of th (Check

State Registrar Stephanie

Baltimore, MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 21 **Physician** October 4:00 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 217-40-3108 Director 1/27/1945 TИ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director MD BALTIMORE CITY BALTIMORE 1 ¥ Yes 2 ☐ No or 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? with 3309 EAST PRATT STREET 21224 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23 Lry or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " the M Elementary/Secondary (0-12) College (1-4 or 5+) 12 CASHIER FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ED REECE ROOSEVELT STATON EDITH GENEVA GRIBBLE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK GOVER - SON 3000 MAYBERRY ROAD, WESTMINSTER, MD 21158 20a. Method of Disposition 1 Nation | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (0=-11) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. ☐ Donation 5 ☐ Other (Specify) CRESTLAWN 10/24/12 MARRIOTTSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKARDA FUNERAL HOME MO 1120 BALTIMORE, MD 21221
respiratory arrest, Approximate 2829 HUDSON ST Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Arrest **Physician** ~ unknown Ectology disease or condition endiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 1 NO 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2: No 1 Inpatient Other: 4 \sum Nursing Home 5 \sum Residence 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred or Attending Patter death.

Director: After the Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital 29a, Certifie 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier RES-000 1) Ctober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJAR HOCHAR

State Registrar 31. Date filed (Month, Day, Year) **NOV 0 5 20**12

DHMH 17 Rev 1/2001 11595

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. Day Dorothy Edna Guillott 2012^{xear} 8:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 218-05-7486 93 **Director** 1 □ M 2 🛛 F Sept. 30 1919 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 🗆 Yes 2 😾 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 8810 Walther Blvd 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 t of Health and Mental Hyglene. If item 27 Is marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Şecondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Schulze Edna Naff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Guillott / Son 8557 Morven Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If its Date 20c. Location - City or Town, State injury or 1 XBurial 2 Cremation 3 Removal from State Moreland Mem. Park 4 Donation 5 Other (Specify) 11/6/2012 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home 21. Signature of Funeral Sancta Line 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive disease or condition resulting in death) Medical Due to (ours a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Industrying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificete be executed the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death 9 Unknown o à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiovascular Pisease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 1 M director, 25. Was case referred to medical examiner? Vital æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ျ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu e and title of certifier 29d. Date signed (Month, Day, Year) R171944 chealles CALP MIN completed cause of death (Item 23a) (Type, Print)

Registrar

State

SOAM

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DOROTHY

Wolfher Blud, Parkulle MO 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1Per PHY C934 12/14/2012 JH
State of Maryland / Department of Health and Mental Hydiene

				ertificate of Dea		, 0	. No. 2 ()	35329		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death		
	Medic		Diane Mac Creene Diane Maria Gree 4a. Facility Name (if not institution, give street and number)		" (D - 1)	October October				
	Examir	ier	13207 Sandston Court	4b. City, Town, or Loca			4c. County of Dea			
7.00	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If U		3. Date of Birth	9. B	George's		
	Director		217 – 56 – 4207 Usual Residence of Decedent 1 □ M ② F 62 Yrs.	Months Days Ho	urs Min.	(Month, Day, Ye 03/23/1	ar) C	WashDC		
	laryland 3a-f shov iffed at	Director	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No		
	with the N s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 13207 Sandston Court	10f. Zip Code 20708		10g	. Citizen of What C	<u></u>		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	I 1 ☐ Never Married 2 ☐ Married I 1 ☐ Yes 2 🔀 No	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 No Spe		fy Yes or No- can, etc.)	14. Race - Am Black, Whi Specify:			
Maryland 21215-0036	iin 72 hou ie. han "natu e Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during DO NOT use retired)	most of working	, 16	b. Kind of Business			
2	d with ygien her ti	Be C	2 001	ntractor			Databas	se		
/land	d be file Mental H arked ot atic ever	To B	17. Father's Name (First, Middle, Last) Owen Harry Proffitt			First, Middle, Maid Zila N	den Surname) Maria By	/ram		
	id 2 shoul salth and I n 27 is m er trauma	10		ing Address <i>(Street and No</i>						
Baltimore,	Page 1 an nent of He unt: If iten iry or oth			osition (Name of matory or other place)	11/2		c. Location - City o	I		
Balti	permit. Departr Importa any inju			2. Name and Address of F				Fun Serv		
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	y con						
ė	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
	ficate be executed g physician and as the burial-transit	al Exar	that initiated events c. The sulting in death) Last c. Due to (or as a consequence of):							
3760	ate be	dic	d							
Box 687	ath cert attendin for use	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year		
, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	Part I.			o the cause of death?		
Records,	aw requir as been 2 should	Completed				24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of		
al Re	sician: The law scrifficate has k	Be Con	25. Was case referred to medical	26. Place of	Death (Check o	performed 1 Yes 2		s 2 🗆 No		
Ĭ	Physician: this certifice ral director,	To E	examiner 1 Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 [☐ Nursing Home	5 Residence	e 6 🗋 Other (Spe	cify)		
on of	ttending Ph death. tor: After th / the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year) 28b. Time of injury		286	•	Residence 6 Other (Specify)			
Division of Vital	ial or Atters after de al Directo	edical Certir	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28	f. Location (Street City or Town, St	t and Number or Ru tate)	ıral Route Number,		
-	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in k	s) and manner as s ace, and due to the ause(s) and manner	cause(s) and manner stated.							
	To t with To t	Σ	29b. Signature and title of certifier	29c. License numb	ber		Date signed (Mont			
	101		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) espital 2	2710		ver ly	202,000		
	Stat	e.	Salvaton Sylvester 3001 He 31. Date filed (Mopth, Dev. Year) 32. Registran Signature	espital I	Nove	che	verly	Maylors		
	Registra	.6	NUV U 5 2012 Charles B. Sparke				,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Director 223-07-8004 1 ፟፟M 2 □ F 98 10/12/1914 NC Usual Residence of Decede or 28a-f shov 10b. Count er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #477 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes Give Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4 or 5+) SASHMAN LUMBER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GLICK ROSE permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY GLICK/SON 3810 GREYSTONE AVENUE, #506, BRONX, NY 10463 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or off MIKRO KODESH BETH ISRAEL 1 🖾 Burial 2 🗀 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 'n 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer disease or condition resulting in death) Medical Due to (or as a consea ence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 🗆 No 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence Schother (Specify) | 12 pahat 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending e Hospital or Attendin 24 hours after death. e Funeral Director: Aft 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, double occurred at the Medical 29a. Certifier To the Hosp within 24 hor To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) mind Miller 27 047683 101 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

DWINGS

Mills

Box

1525

32. Registrar's Signature

HARGIS, DEBORAH

•	-	For State		State of	Marylan		artment of H rtificate of D		-	21) 2	35331
		Registrar Decedent's Name (First, M.)	/liddle, Las	st)			rimodic or B	, catir	2. Date of Dea			3. Time of Death
Physicia Medi		Deborah			indora	a	Harg		OCT-3E	2 2 S	Year Zo 12	08:38 PM
Examir	ier	4a. Facility Name (if not instit			,	TRE	4b. City, Town, or BALTI			4c. Coun	ty of Deat	h
Funeral		5. Social Security Number	6. S		. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		9. Birt	hplace (State or Foreign untry)
Director		214-58-855 Usual Residence of Decede		□ M 2 K] F	60	Yrs.		I TIOGRA		4 52	00.	MD
land show dat	φ	10a. State 10b. Co			10c. Cit	ty, Town or Lo	ocation	<u> </u>				10d. Inside City Limits
Mary 28e-f	Director	MD	NA	V		Balti						1 🎇 Yes 2 🗌 No
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eath w	Funeral	11. Marital Status	110	12. Was Deced	ent Ever in U.		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. R	ace - Ame	rican Indian,
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene, ritem 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Exeminer must be notified at	ed by	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 Yes If Yes, Give Year or Dat	2 🕅 No		1 ☐ Yes 2 💢 No		nican, etc.)		ack, White f_y : $\mathrm{B} 1$	
15-0	Completed		cedent's E highest gr	ducation ade completed)		(Give	dent's Usual Occupa	ation luring most of work	king	16b. Kind of	Business/	Industry
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nd filed v	Be C	17. Father's Name (First, Mid	idle, Last)					18. Mother's Nam			me)	
TY a	욘	Roosevelt				_		Jeanett				
Ma 12 sho lith end 27 is r		19a. Informant's Name/Related Sharenne C			uahtei		ing Address (Street a Paula P					e, Md
of Head of Head of Head fitem		20a. Method of Disposition 1 🔯 Burial 2 🖸 Crema			20b. F	Place of Dispo	osition (Name of matory or other place	-	Date	20c. Location		
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other once.		4 Donation 5 Otl	her (Speci	fy)	June	ng Mei	morial P	ark 11/	/3/201	Wood	lawn	, Md
Baltimol permit. Page 1 Department of Important: If i eny injury or o		21. Sight ture of Funeral Sen	vice Licen:	3. K	eke	IM:	2. Name and Addres arch F/H 300 Waba	I West	Ralti	more.	ма	21215
		23a. Part 1. Enter the disease shock, or heart failure.	se, or com List only o	plications that ca	used the deat							Approximate Interval Between
~ Physician/	i i	Immediate Cause (Final disease or condition			515							Onset and Death
Medical Examiner			ſ	Due to (c	r as a consequ	uence of):		TATS				Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/1/2012 Physician/ 2:45 P M Hilda M. Haugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🖾 F 219-20-4207 Yrs 2/15/1925 MD 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Carroll Hampstead MT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1385 N. Main Street 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 K No Black White etc. ō 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) McDougal's Pharmacy 11 Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည should be Esther Pickett Floyd Barnes and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a tem 27 is 2 P.O. Box 756, Hampstead, MD 21074 Eric Haugh/Son If item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ō Important: If if any injury or o 1 Burial 2 Cremation 3 Removal from State Highland View Cem. 11/7/2012 Berrett, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Onset and Death 515 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) ed by the a q I IInknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de 2 To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Division of Vital 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending work? Accident
Suicide 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and or inventioning in the cause of examination and/or inventioning in the cause of examination and or invention and or inventio Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar and address of person who completed cause of death (Item 23a) (Type/Print)

32. Registran's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $\overset{\text{Day}}{30}$, Month Physician/ Harfmann 2012 George 4:24a^M John October 0 Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner St. Joseph Manor 911 W. Lake Ave. Baltimore City 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) If Under **Funeral** Oct. 24,1935 Hours 051-30-7690 **Director** 1 X M 2 🗆 F New York Usual Residence of Deceden chow 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location must be notified at Director N/A 1XXYes 2 ☐ No Baltimore City Maryland 28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10 Funeral 21210 U.S.A. with 23a 911 W. Lake Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status an "natural", or iter Medical Examiner Armed Forces Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHite "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Roman Catholic Priest Church Department of Health and Mental High Important: If item 27 is marked other any injury or other traumatic event, 1 once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Harfmann Anna Schubert 19a. Informant's Name/Relationship (Type, Print) Priest St. Joseph Society Sacred Heart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21202 1130 N. Calvert Street 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place New Cathedral 11/7/2012 BAltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 5305 Harford Rd. Wantsor Leonard J. Ruck, Inc. facy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY disease or condition Medical resulting in death) PISEASE **Examiner** ESENTERIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atten in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 hnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending after death.

Director: Aft
d in by the fur Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F
complet 29d. Date signed (Month, Day, Year) 29b. Signature and title of ced D0054952 10/51/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOHN T. EVELIUS, HD. 7600 ON Drive Suite 308

State

Registrar

31. Date filed (Month, Day, Year,

NOV 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Betty Althea Ingra	1	- For State	Sta	te of Mar	ryland / [epartme <i>Certifica</i>		Health and Death	Menta	Hygie		g. No. 20	12	35331
Physiciar Medical Examin	1/	Decedent's Name	(First, Middle,	Last)	00 -	70 - 60	200				ate of Death Sonth ctober 30	h	- 1	Time of Death 0751 hrs
ann		la. Facility Name (if)		give street an	d number)	11910		City, Town, or L			-	4c. County of E		-
Funeral Director		5. Social Security Nu 252-44-		. Sex	1	n yrs. last birth		If Under 1 Year Months Days	If Under 2 Hours	4Hrs. 8. Min.		-1935	orgina	ce (State or
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h the Mary 3a or 28a-	합	3912_	Lane	erda	le C	Burt			133			g. Citizen of What	A	·-
after death witl al", or items 2 ner must be n	by Funeral	Marital Status Never Married Widowed		ried Arme	Decedent Eve ed Forces? es 2	No No	If Yes	Decedent of Hisp specify Cuban, es 2 No	Mexican, Po			14. Race - A White, e Specify:		Indian, Black,
5-0036 led within 72 hours after de yagiene. other than "natural", or the Medical Examiner m	ompleted t	15. Decedent's Edu		y only highest	grade comple ge (1-4 or 5+)	dı		Usual Occupation of working life. I			done	16b. Kind of Busin	ess/Indus	Care
MD 21215-0036 d.2 should be filed within 7 lift and Mental Hygiens in 27 is marked other than aumatic event, the Medica	Be C	7. Father's Name (F \(\mathcal{O} O S \(\mathcal{O} \) e 9a, informant's Nam	1+ -	Lner	ram	19b.	Mailing A		Eliza	abe	th	faiden Surname) Log L ber, City or Town,	CVS State, Zip	Code)
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Balt permit. Departi Importinjury		Signature of Fundament	. C. 1	Drun	e		87	and Address of Libe	esty!	2000		dallston		1_21133
Physician /Medical Examiner		23a. Part I. Parer the failure Ust only immediate Cause (Fi or condition resulting	one cause of inal disease	a. Atheros		rdiovascula			such as card	iac or resp	piratory arre	st, snock, or neart		oproximate Interval etween Onset and Death
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, P.O. Box 68760 res that the death certificate signed by the attending phy. be detached for use as the be	cian/l	3b. Was decedent properties past 12 months? 1 Yes 2 No.	_	1 Li	ve birth regnant at time eath nknown	2	_	death 3 (Specify)	Ectopic pr	regnancy		Month	Day	Year
P.O. es that the signed by be detach	i i	Part II. Other signific	cant conditio	ns contributir	ng to death bu	t not resulting	in the und	erlying cause giv	ven in Part I	_ [1 Yes			ause of death?
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for unity of the funeral director, page 2 should be detached for the funeral director.	Complete											sy prio	r to comp	y findings available letion of cause of
/ital /sician: /sician: /sician:	ge '	25. Was case referre examiner? 1 ✓ Yes 2		Hospital: 1	Inpatient	2 ER/Out	patient 3		of Death (Ch Other N	ursing Ho		Residence 6 🗸	Other: Sce	ene
ion of \\ ttending Phy leath. tor: After th the funeral	ation: 10	7. Manner of Death	5 Pendir	g (N	Date of Injury Month, Day,Year)		me of Inju		at Work?		Describe h	ow injury occurred		
Divis pital or At ours after c eral Direc filled in by	팅 .	3 Suicide 4 Homicide	6 Could determ	not be 28e. F		- At home, far	m, street,	actory, office bu	ilding, etc.		Location (S or Town, St		r Rural R	oute Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 V	ledical Exam		sis of examina			, in my opinion,	death occur			e(s) and manner as and place, and due	to the cau	
	Ē :	9b. Signature and ti	tle of certifier	1. 1	£	_		29c. License O. C.N				29d. Date signed November 5,		Day, Year)
)		0. Name and addres Jack Titus Mi	D. Depu	ty Chief Me	edical Exar	miner 900) W. Ba	Itimore Stree	et, Baltim	ore, ME	21223			
Stat Registra		1. Date filed (Month) NOV 0 5			2. Registrar's S	_	_					.		
DHMH 17 Rev 1/200	1	110100	2012	Chown	A.	pare	GINAL				DC	ME		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Dawson Jones October 2012 4:20 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 213-22-2931 1 M 2 X F 87 July 09, 1925 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14021 Rippling Brook Drive 20906 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Perry Dawson Alberta Wood Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Casey Jones-Spouse 14021 Rippling Brook Dr., Silver Spring, MD 20906 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Baltimore, Crematory
at Loudon Park 1 Burial 2 X Cremation 3 Removal from State 11/02/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 omplications that salsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the di ease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 as attending for use as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by **Breast Cancer** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus autopsy performed? Yes 2 No Transient Ischemic Attack 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20850

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

5 2012

Box

P.O.

Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Α. Keene, Jr. Ernest 201 D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours 51 215-74-8798 Director 1 🛛 M 2 🗆 F Jan.13,1961 MD th and Mental Hygiene. 27 Is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1567 Alconbury Rd. Apt.I 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Treemont Hotel Service Worker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 Is marked of any Injury or other traumatic eve ဂ္ Ernest A. Keene, Sr. Emma Muse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 N. Caroline St. Balto, Md. 21213 Alicia Keene (daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Bayview Crematory Nov.5,2012 4 ☐ Donation 5 ☐ Other (Specify) Balto, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiomyo path months disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Surcoido si Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate physician and s the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? signed by the a ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ; page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Ofther (Specify) Hospic P Hospital 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Baltinure MD 21204 charles 6701 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 29d, per phy, g933 11-5-12 sm State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ October Kerfoot Charles 2012 09:55AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 02 1940 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 547-50-5303 Director 1 **X** M 2 □ F 72 Yrs CA Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 🗆 Yes 2X No Pasadena Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21122 USA 133 Wileys Lane Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Xes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Electrial Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ၉ Anna F. Drew Leland Kerfoot B. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 133 Wileys Lane, Pasadena, MD 21122 Gail P. Kerfoot (spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. Date 02 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2012 Baltimore, MAryland 21. Signature uneral Service Lice 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final PARCIN OMA MERKEL CELL Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Little, Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Melanoma Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 🗌 Yes MICC 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No м Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of pertifig 29c. License number 10×1 30/Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 27 12:27 pm 2072 Charles Preston King, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14313 Georgia Avenue. #104 Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funera Months (Month, Day, Year) Days Hours 213-46-8433 **Director** Yrs 10/28/1947 Maruland 64 Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 14313 Georgia Avenue, #104 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Melinda Mulligan Harvey Detrow King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14313 Georgia Ave., #104, Silver Spring, Maryland 20906 Alma Joann Carpenter/Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other in 20a. Method of Disposition 20c. Location - City or Town, State ematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/03/2012 | Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signatura of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a considerance of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c}\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 💢 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 (1) 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D58962 November 01, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 18121 Georgia Avenue, Suite 103, Olney, Maryland 20832

Registrar DHMH 17 Rev 06-2011 Shashank G. Patel,

31. Date filed (Month, Day, Year)

NOV 0 5 2012

32. Registrar's Signature

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<u> - </u>		Balnno 5. Social Security No		MEDICA:	7. Age (In yrs		hday)	BALT7		ORE If Under 24 Hrs.	8. Date of B	irth		0 Dirthn	Inco (State or Fereign	_
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (I		Kimbal	1 Sr					18. Mother's Nam	ne (First, Middle Chane		n Surname)		
ould b nd Mer mark imatic		19a. Informant's Na				19h	Mailing	o Address (Str	et ar	nd Number or Rui			or Town S	tate Zin C	tode)	_
d 2 sh salth ar n 27 is er trau		Mary Re	becca	Murray	ithAge	nt 64		-		ad Risi				-		
ge 1 an t of He if item or oth		20a. Method of Disp		☐ Removal from				sition (Name of atory or other			Date	20c. 1	Location -	City or To	wn, State	
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Physician/		Immediate Cause (_a_1Sc	HEM	10	CA	ROION	14	OPATH	<u> </u>				Onset and Death	
Medical Examiner		resulting in death)	-	Due to	(or as a conse	equence o);				•				oyears	
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that the	by Pi	Part II. Other signif						nderlying cause	give	en in Part I.					e cause of death?	
een sig	eted	Diaba	etes M	leuths	TYP	6 TT	-								pably 4 W Unknown	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Luneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Example 1	hysician: To the laminer: On the ballurse Practitione	sis of examinat	tion and/o	r investi	gation, in my o	oinior	n, death occurred a	it the time, date	and plac	e, and due	e to the cau	se(s) and manner state	ed.
To the within To the Comple	Σ	only one) 3 29b Signature and		idise Practitione	r: 10 tile best c	JI IIIY KIIOV	vieuge, (29c. Lice			ace, and due to			(Month, E		_
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DHMH 17 Rev 06-2011

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State of Maryland Department of Health and Mental Hygiene 2 0 1 2 3 5 3 4 0

		1	State Registrar		,	Cer	tificate	e of D	eath		F	د Reg. No.	_ 0 : L		7 5 5 7 0
	Dhysisis	~ /	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month		Year	3. 7	Time of Death
	Physicia Medic		MARK	KHEYS	SON						NOVEMB1				3:28 A ^M
1	Examin	er	4a. Facility Name (if not institution				, ,		Location o	of Death		4c. C	ounty of Deatl	h	
	Francis		SINAI HOSPITAL 5. Social Security Number		(In yrs. last	birthday)	If Under	LTIM 1 Year		24 Hrs.	8. Date of Birtl	n .	N/A 9. Birt	hplace (State or Foreign
10	Funeral Director		220-59-3746	1 🖾 M 2 □ F		Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	Cot	intry)	4 7 7 7 7
	*		Usual Residence of Decedent		82						04/02/	1930			AINE
	yland •f show ed at	lg	10a. State 10b. County		10c. City, To										side City Limits Yes 2 No
	e Mar r 28a notifi	jie	MD BAL'	rimore	BA	LTIM	ORE 10f. Zip	Code				10a Citiza	en of What Co		163 2X 100
	ith th	Funeral Director	6930 MARSUE DI	מדנים אסיי 1ה			101. 210		215			rog. Onize	USA	artity.	
	ems :	ine	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Deced	lent of His	spanic Ori	gin? (Spe	ecify Yes or No-	14	. Race - Ame		lian,
98	e filed within 72 hours after death with the Manyland Ital Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	b	1 Never Married 2 🛚 Mar	If Von Give	lo		Yes, spec				Rican, etc.)	St	Black, White pecify:		T
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	and Healt		IRINA KHEYSON 20a. Method of Disposition	/WIFE		e of Dispo	sition (Nan	ne of			Γ. 1D, I		MURE, 1 ation - City or		21215 state
nor	4. O		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1		natory or o			11/0	2/2012	RF	ISTERS'	TOWN	MD
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line.	the death. [Do not ente	er the mod	e of dying	g, such as	cardiac	or respiratory arr	rest,		Inter	roximate val Between
-11	hysician/		Immediate Cause (Final disease or condition	Can	clia	C	ar	res	7		14.	5.		Ons	et and Death
-	Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):	11 (0	no	Lha	, ,	127.	8			
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8760	tte be hysici the bu	Medical		d			<u> </u>								
687	ertifica ding p	-	IF FEMALE:	23c. If yes, outcome of	of pregnance	v						2	3d. Date of de	liven	
Вох	ath certi attendin I for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 Live Birth 2 4 Pregnant at	2 🗌 Fetal d	eath 3	Ectopic Other (s		СУ				Month	Day	Year
. B	that the dea ned by the a e detached i	Physician/	g Unknown	9 🗌 Unknown											
P.0.	that med b	by P	Part II. Other significant condition	ons contributing to death bu	ut not resulti	ing in the ι	underlying	cause giv	ven in Part	I.			e contribute to		
ds,	requires the been signer should be a	ted					_				1 🗆	Yes 2			4 Unknown
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of Vital	sician: The certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	V .	2/0-4	-+ 0 🗆 D	Oth	or:		<i>k only one)</i> ome 5 ☐ Resid	danaa C [T Other (Spec		
of V	y Phys er this eral di	e: To	27. Manner of Death	1 ☐ Inpatie	y 28	3b. Time o		28c. Injur	y at	ursing H	28d. Describe h			211Y)	
uc C	death. ctor: After y the funer	icat		gation	rear)	injury	М	work	Yes 2] No				_	
Division		Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		ry - At home . (Specify)	e, farm, str	eet, factor	y, office			28f. Location (S City or Tox	Street and vn, State)	Number or Ru	ıral Rout	te Number,
Ö	pital cours af		29a. Certifier 1 Certifyin	Physician: To the best of	my knowlod	lao dooth	occurred s	t the time	e date and	d place a	and due to the c	ause(s) and	d manner as s	tated	
	24 hc 24 hc Fune letely	Medical	(Check 2 Medical	Examiner: On the basis of examiner: To the basis of examiner: To the	amination a	nd/or inves	tigation, in	my opinio	on, death o	ccurred a	t the time, date a	and place, a	and due to the	cause(s)	and manner stated
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	2	20h Signature and title of editifie	r .	111				e number				signed (Mont		
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	3(1)		30. Name and address of person						D -		206 -		ODE 35	D 01	015
	V		ALEXANDER POK 31. Date filed (Month, Day, Year)	OV, M.D., 682		_	STOWN	KOA	D, S	UTTE	206, BA	ALTTM	ORE, M	D 21	. ∠15
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall Baltimore County 77 Jumpers Circle If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 23,1973 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 215-04-4526 39 Maryland Director 1 X M 2 | F ed other then "neturel", or items 23e or 28a-f show event, the Madical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Heelth end Mentel Hyglene. Important: if item 27 is merked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Marcal Examiner must be notified at any injury or other treumetic event, the Marcal Examiner must be notified at appear. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall Maryland Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21236 77 Jumpers Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ۵ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 2 vrs Elementary/Secondary (0-12) Group Benefit Services Business Analyst yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kraft Marguerite J. Tittsworth Richard Andrew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
77 Jumpers Circle Baltimore, MD 21236 19a. Informant's Name/Relationship (Type, Print) Mrs. Doreen Kraft -20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other Holv Redeemer 11/5/12 Baltimore, MD 4 Donation 5 Other (Specify) Baltimore, Marylanu 212 Inc. 5305 Harford Rd. 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that cause the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physicien end use es the buriel-trensit or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 1 Yes 2 9 Unknown been signed by the should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth ☐ Accident Investigation 3 Suicide 6 ☐ Could not be To the Hospitel or Atter within 24 hours effer der To the Funerel Director completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Arint)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2-08185 ouis A Lowentha		Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental			2 3534				
Physician	R	1- For State Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	eg. No.	3. Time of Death				
Medical Examin		Louis Ashok Lowenthal	Month October 3	Day Year 1, 2012	1801 hrs				
	4	4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Dea Baltimore	ath	4c. County of Dea	th				
Funeral Director	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24+ 212-53-3568 1 North 2 F 14 Yrs. Months Days Hours N	1rs. 8. Date of Bir 1in. 05/15	th(MM/DD/YYYY) 9. B /1998 Fore					
b	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
Maryland 28a-f show any d at once.		Maryland Baltimore Stoneleigh			1 Yes 2 No				
with the Maryland ns 23a or 28a-f sho be notified at once.		10e. Street and Number 10f. Zip Code 21212	1	0g. Citizen of What Co U.S.A.	untry?				
r death	Funeral	11. Marital Status 1 \(\bar{X}\) Never Married 2 \(\bar{Married}\) Married 3 \(\bar{Y}\) Widowed 4 \(\bar{D}\) Divorced 1 \(\bar{Y}\) Status 2 \(\bar{X}\) No 1 \(\bar{X}\) Status 2 \(\bar{X}\) No 1 \(\bar{X}\) Status 2 \(\ba		14. Race - Ame White, etc. Mi	rican Indian, Black, Xed				
27	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use of Student		16b. Kind of Business					
be findal riked	e a	Eric E. Lowenthal Chloe							
MD 21 d 2 should lth and Me n 27 is ma tumatic ex	L	19a. Informant's Name/Relationship (Type, Print) Eric E. Lowenthal Father 707 Chumleigh Road	Baltimor	e, Maryland	1 21212				
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If iten 27 is in injury or other traulant		4 Donation 5 Other Specify:		Hanover,	Maryland				
Ball permit Depar Impo	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ma nucleal Navyell- 6009 Harford Road	Baltimo	re, Marylai	nd 21214				
Physician Medical Examiner	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	c or respiratory arr	est, snock, or heart	Approximate Interval Between Onset and Death				
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ted nsit	CXam	(U)sease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
E 5 6		☐ AMENDED 23a,27,28a-f,per me,g935 1-9-	13 sm	-					
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be exter this certificate has been signed by the attending physician reral director, page 2 should be detached for use as the burial of Commission Hospital	ly sician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
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Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical examiner? 1 Yes 2 No		Residence 6 Othe	A.C.				
ion of Vil tending Physic eath. tor: After this the funeral dire	- 12	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe I	how injury occurred					
Division o spital or Attending sours after death. oeral Director: Aft filled in by the func		Natural 2 X Accident S Pending Investigation A Accident S Pending Investigation 2 Re. Place of Injury - At home, farm, street, factory, office building, etc.	pool	found at	ural Route Number, City				
File but		Suicide Could not be determined (Specify) Swimming Pool			conworth Ave				
Division To the Hospital or Attent within 24 hours after death within 42 hours after found to the Fuoreral Director: completely filled in by the found in a fille	a la	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		and place, and due to t	he cause(s)				
	∑ 2	29b. Signature and title of certifier 29c. License number O.C.M.E.		November 2, 20					
6	3	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Balt	imore, MD 21	223					
Stat Registra		31. Date filed (Month, Day, Year) 32. Rigitiver's Signature		OGME					
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		1	State of Ma	ryland /	-	rtment of H tificate of D			giene Reg. No.	2 35343
		_	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Yo	3. Time of Death
	Physicia Medic	ai .	WAYNE Nicholi	A 3	4	4pch A		OC+	27 20	12 1113 M
	Examin	er	4a. Facility Name (if not institution, give street and number) 234 W. Arden Road			4b. City, Town, or Balt:	imore		4c. County of D	rundel
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h 9. (Year)	Birthplace (State or Foreign
-	Director		217 58 1196 1 XI M 2 L F Usual Residence of Decedent	58	Yrs.			06/01/2	1954	Maryland
	land show dat	tor	10a. State 10b. County	10c. City, To						10d. Inside City Limits
	Mary 28a-1	DE L	Maryland Anne Arundel	Balt	timor	e 10f. Zip Code			10g. Citizen of Wha	1 Yes 2 X No
	vith the 23a or st be	ral [234 W. Arden Road			21225	;		U.S.A	-
	leath v items er mu	Funeral	11. Marital Status 12. Was Decedent Evarmed Forces?	ver in U.S.	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e	d by	1 Never Married 2 Married 1 Yes 2 M If Yes, Give	No	- 1	☐ Yes 2 🛣 No		, ,	Specify:Wh	
21215-0036	hours natura dical E	Completed by	15. Decedent's Education (Specify only highest grade completed)	16	6a. Deced	ent's Usual Occupa	ation	ina	16b. Kind of Busin	ess Industry
121	within 72 giene. ier than " t, the Me	mo	Elementary/Seconday (0-12) College (1-4 or 5-	+)	life. DO	NOT use retired)	aring most of work	ing	Baltimo	ore City
9	led wit Hygie other ent, th	a	12 17. Father's Name (First, Middle, Last)		Tayı	011	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ylan	should be filed and Mental Hy rand Mental Hy rs marked oth raumatic event	잍	Michael Lap	chak			Rose	e Parada	1	
Maryland	shoul h and l 7 is m trauma		19a. Informant's Name/Relationship (Type, Print)			-			r, City or Town, State	e, Zip Code) vland 21225
e,	and 2 Health tem 2		Marie Lapchak / wife 20a. Method of Disposition	20b. Place	e of Dispos	J. Arden sition (Name of		Date	20c. Location - Cit	
mo	Page Tent of		1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			natory or other placerematory	11/05	/2012	Baltimor	e, Maryland
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trae		21. Signal of uneral Seven hee			Name and Addres			ral Servi imore, Ma	ce, P.A. ryland 21225
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line.	the death. De	o not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
-41	hy i i n Medical	0.0	Immediate Cause (Final disease or condition resulting in death)			ine ,	Henrit	121	SEASO	Onset and Death
	Examiner		Due to (** 4 a	consequence	te of):	3				
Ļ	_ +	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	consequenc	ce oi).					
go	ecuted and -transi	Examiner	Cause (Disease or iinjury that initiated events c	consequenc	ce of):					
v 09	ate be executed physician and the burial-transit	dical	d							
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Box 687	ath cer attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 🗌 Fetal de	eath 3 🗀	Ectopic pregnand Other (specify)	÷y		23d. Date of Month	-
Ö.	the de	hysi	9 Unknown							
s, P.O.	requires that the death certifics been signed by the attending p should be detached for use as '	by	Part II. Other significant conditions contributing to death be	ut not resultir	ng in the u	nderlying cause giv	ven in Part I.			te to the cause of death?
ord	w requ	Completed						24a. Was		re autopsy findings available or to completion of cause of
Rec	The law cate has page 2:	Com						perfo	rmed2 dea	th? Yes 2 No
ital	sician: certific rector,	Be c	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital:		<i>'</i> 2	Oth	ace of Death (Chec	^	d	D===(6.)
of V	g Physer this leral di	e: To	27. Manner of Death 28a. Date of injur	y 28	b. Time of injury	at 3 DOA 28c. Injury	y at		dence 6 Other (S	Specify)
lon	eath. or: Aft	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 No			
Division of Vital Records,	lor At after c Direct		4 Homicide determined 28e. Place of Injubuilding, etc		, farm, stre	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
٢	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the basis of examiner on the basis of examiner. Certifying Nurse Practioner: To the last of examiner.	camination an	nd/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Dep	uty	29c. License	e number	/	29d. Date signed (A	
	10		30. Name and address of person who completed cause of de	eath (Item 23)		695	Amer	TEA	2103	5
	Sta	te	001100	r's Signatue	1	. N. J				
	Registr	ar	MANA O O SOIS CERMINA	Ja.	190					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 35344 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31 Herman Liebling 7:42 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 099-01-8725 Director 1 X M 2 □ F 96 10/20/1916 New York th end Mental Hygiene. 27 is marked other than "netural", or Items 23e or 28a-f show treumetic event, the Medical Examination must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Bethesda 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? by Funeral 9707 Old Georgetown Road 20814 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Economist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Liebling Rose Levenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health er Important: If Item 27 is any Injury or other treu Lynne Liebling - Daughter 3rd Avenue, #402, San Diego, California 92103 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grdns [11/07/2012 | Falls Church, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatore of Funeral Service Lice MO1355 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Right Pleural Effusion disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute on Chronic Kidney Disease Securation of the second securation of any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) <u>Pulmonary Hypertension</u> that initiated events resulting in death) Last Physiclan/Medical Congestive Heart Failure Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Atrial Fibrillation Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown G, Parkinson's Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 0 <u>Ischemic Cardiomyopathy</u> death? 1 ☐ Yes <u>2 ☐ No</u> 25. Was case referred to medical **Division of Vital** Z 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Rm 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be C 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S.Deli'stathis D59980 October 31, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) Sandra M. Delistathis, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Ment State Certificate of Death	2012 35345
Registrar Certificate of Death	Reg. No. 2 0 2 3 Time of Death
Physician/ Gloria ANN Lane	North Bay 2012 10:47 PM
Pxaminer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
3949 Boarman Ave Baltimone	N/H
Funeral 5. Social Security Number 6. Sex 1	ate of Birth 9. Birthplace (State or Foreign Country) 123/49 MD
Havel Benidense of Decedent	/23/49 MD
To a State 10b. County 10c. City, Town or Location N/A Baltimore	10d. Inside City Limits
MD MA Baltimore	1 ☐ Yes 2 ☐ No
Sound residence of December 2 10c. City, Town or Location Baltimore The part of the par	10g. Citizen of What Country? USA
The state of the s	
Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, University of the state of the specify Cuban, Mexican, Puerto Rican, University of the specify Cuban, Mexican, University	Black White, etc. African Specify: Amer
TO TO TO TO TO TO TO TO TO TO TO TO TO T	
15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry Movie Theater
The secondary (0-12) College (1-4 or 5+) Hostress College (1-4 or 5+) College (1-4 or 5+) Hostress College (1-4 or 5+) College (1-4 or 5+) Hostress College (1-4 or 5+) College (1-4 or 5+) Hostress College (1-4 or 5+) Hostress College (1-4 or 5+) College (1-4 or 5+) Hostress College (1-4 or 5+)	Movie Theater
To be to be a second of the se	t, Middle, Maiden Surname)
B N S E E E E E E E E E E E E E E E E E E	
19a. Informant's Name/Relationship (Type, Print) Larry Lane/Son 19b. Mailing Address (Street and Number or Rural Rout) 5521 Nome Ave, Balt.,	MD 21215
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Date Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State Bayview Crematory or other place) 4 Donation 5 Other (Specify)	
The part of the pa	P. Close F.Sys.PA t.MD 21206-5105
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp	
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Interval Between Onset and Death
Medical resulting in death) a. Due to (or as a consequence of):	
Examiner Sequentially list conditions, b.	
if any leading to immediate Due of the ras a consequence of: cause. Enter Underlying Cause (Disease or linjury)	
that initiated events resulting in death) Last C. Due to (or as a consequence of):	
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	
V So to the state of the state	
23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
XO X O T T T T T T T T T T T T T T T T T	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
y requires six should be six s	1 Yes 2 No 3 Probably 4 Unknown
5 2 2 2 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
The state of Death (Check only)	1 Yes 2 No 1 Yes 2 No
Solution in the state of the st	SAResidence 6 Other (Specify)
27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending	Describe how injury occurred
To get a get	
The condition of the co	ocation (Street and Number or Rural Route Number, ity or Town, State)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	to the cause(s) and manner as stated.
(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.
29b. Signature and title of certifier 29c. License number 453058	Notember 2,2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
craig Gold Do 1838 Greene Tree Road \$135 Battim	tre, Maryland 21208
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35346 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month (0 Physician/ Ada Marconi 2012 2202 M Medical Facility Name (if not institution, give street and nu **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Harford Bel Air Min Chesape alce Hospita If Under 1 Year I If Under 24 Hrs Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 219-30-1655 1 □ M 2 🏝 F Director 90 Yrs 07/08/1922 Italy or 28a-f show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits hours after death with the Maryland "natural", or items 23a or 28a-f s edical Examiner must be notified MD Harford Fallston 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21047 1805 Abelia Rd. IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tailoring Company Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Abelia Rd., Fallston, MD 21047 Enzo Marconi - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2012 Baltimore, MD 4 Dongtion 5 Other (Specify) Lorraine Park of Funeral Service Licensee 21. Signatu 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiac disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? this certificate Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 E 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 🔲 No Investigation after death Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contriving Nurse Prantitioner: To the best of my howledge, ceath occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69196

State Registrar

0/30/2012

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500 Opper Ohesapeake Drive Bel Air, MD 21014

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cause of death (Item 23a) (Type, Print)

30. Name and address of person wh

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Jolie

Registrar

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State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Calvin C. Maddox, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Sept Day Your, 1958 213-72-6119 54 MD Director 1 ☐ ¥M 2 ☐ F Usual Residence of Decedent 10c. City, Town or Location ir then "natural", or Items 23e or 28e-f sho the Medicel Examiner must be notified et 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Baltimore ty Ves 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3514 Parklawn Ave. 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 X Never Married 2 Married ۾ Black 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) D.C. Dept. of Elementary/Secondary (0-12) College (1-4 or 5+) Corrections yrs Correctional Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental permit. Page 1 and 2 should be Department of Health and Mental. Important: If item 77 is more any injury or other. and Mental Calvin C. Maddox, Sr. Helen Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtice Harris (Fiance) 3514 Parklawn Ave. Baltimore, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Cathedral Cem Nov.7,2012 Balto, Md. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Baltimore Μđ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hero Scleritic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Years Hospital or Attending Physician: The law requires that the death certificate be executed use es the buriel-trar ettending physician end for use es the buriel-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
Unknown 5 ☐ Other (specify) Month Day Pregnant at time of death signed by the ef 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funerel Director: After his certificale has been si completely filled in by the funerall director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗹 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonne Muyland 21229 Conges Mi) 5601 Lix L Kaver 32. Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monally 11:21PM Gordon October Vennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Harbor Baltimore N/A 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Aug. 21 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 6 Sex 5. Social Security Number **Funeral** Country) Months Hours Min 214-30-6871 79 MD **Director** 1 🛛 M 2 🗆 F Yrs Usual Residence of Deced 10d. Inside City Limits 28a-f show 10h County 10c. City, Town or Location 10a. State items 23a or 28a-ı snu ier must be notified at Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 936 Lombardee Circle 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Examiner Black, White, etc. or . Completed by 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify. "natural", 3 Widowed 4 Divorced th and Mental Hygiene.

I is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Dry Dock Pipe Fitter 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown McNally Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other tratonce. 936 Lombardee Circle, Glen Burnie, MD 21060 (spouse) Josephine L. McNally 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 01 Nov 1 XBurial 2 Cremation 3 Removal from State Glen Haven Cemetery Glen Burnie, Maryland 2012 Donation 5 Other (Specify) Sign ture of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 MountainRoad, Pasadena, MD 21122 et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Interval Between Onset and Death

4 day s Immediate Cause (Final Physician/ Pain Ischemic Abdominal disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Year Anemia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Disease Coronar 4 Arceny Tears or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown been signed by ti should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown of Vital Records, Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? 1 Tes 2 X No certificate 1 🛛 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 ☐ Yes 2 ☒ No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending iniury 1 X Natural Division Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 RES 00 October, 25th, 2012 511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanoner MP 21225 Baltimore, South Street 3005 Hao Lin

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month $20\overset{\text{Year}}{12}$ Physician/ Joseph B. McDade 12:04 P.M November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner N/A Harbor Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Months 214 20 2938 Director 1 X M 2 □ F 84 12/21/1927 Maryland Usual Residence of Deceden 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 🌠 No Maryland Anne Arundel Linthicum 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a (Examiner must be Funeral U.S.A. 401 Hance Avenue 21090 death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 【 Yes 2 □ No If Yes, Give WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married ð filed within 72 hours after 3altimore, Maryland 21215-0036 ian "natural", o Medical Exam 1 ☐ Yes 2X No Specify. Specify: White WW II 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking 6 Page 1 and 2 should be filed wil nent of Health and Mental Hygie ant: If item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Myrtle Workman Joseph McDade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7911 Red Globe Court Severn, Maryland 21144 Joann McDade / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State MD State Veteran Cem. 11/07/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway americas holications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List on Sonset and Death Immediate Cause (Final Phonicina disease or condition resulting in death) Medical **Examiner** ENSION Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖲 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signat and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

DO04049

11-01-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 5:33 A M Winifred I. Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt<u>imore</u> Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 127-10-0159 Director 1 □ M 2 🗓 F Yrs 26, 1914 New York 98 Jan. Usual Residence of Deced Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evanniner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No Baltimore MD Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral #219 21204 USA 1055 W. Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify: Completed 3 X Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Patrick Walsh Muriel Isabell Desnoes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Morris son 205 Paddington Road; Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or oth 1 Burial 2 remation 3 Removal from State 11/8/2012 Owings Mills, MD Garrison Forest 4 Donation 5 Other (Specify) 21. Signature of Furleral Service Licensee 1050 York Road 22. Name and Address of Facility Inc. MD 21204 Ruck Towson Funeral Home, Towson, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, deach line. 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final minari Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify WS D14 2 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 5 OCTOSES 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST AMON W NOINST 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ David McNulty 10726/2012 4:450 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4511 Dallas Place #1 Temple Hills Prince George's Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 TTA **Funeral** 8. Date of Birth Days 1**X** M 2 □ F 230-92-4203 51 0670671961 **Director** VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Temple Hills 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Dallas Place #1 Funeral 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. "natural", or 1 XNever Married 2 Married ρ ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waiter Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Raymond Edward McNulty Peggy Hensley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
103 Lancelot RD Salisbury NC 28147 Page 1 and 2 strength of Health a tant: If item 27 is Peggy Bollinger Mother 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 11/01/12 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Superal Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ESOPHAGEAL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HIV Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al completed filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

68760

Box

P.O.

Records,

Division of Vital

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

J. n.ton

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 04, Physician/ 9:19 am Martin Oler 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 577-38-8942 1 🕱 M 2 🗆 F Director Yrs Pennsylvania 82 01/03/1930 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number Funeral Page 1 and 2 should be filed within 72 hours after death with 20901 U.S.A. 10605 Stoneyhill Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 10 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Salesman Automotive Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked ဂ္ (Unknown) Bessie Morris Oler other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10605 Stoneyhill Court, Silver Spring, Maryland20901 f Health Annette Oler - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem Gardens 11/06/2012 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. The Marie Warner 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a conscious record Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 🥓 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Other (specify) signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 🗶 ER/Outpatient 3 ☐ DOA မ After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn J. Sporn. M.D.. 1500 Forest Gle

Carolyn J. Sporn,
31. Date filed (Month, Day, Year)
NOV 0 5 2012

D58461

1500 Forest Glen Road, Silver Spring,

November 04, 2012

Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ PM Helen E. Price 2012 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris
Social Security Number 6.5 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Country 228-30-1982 Director 1 🗆 M 2 🗶 F 83 11/24/1928 VA Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director N/A MD 1 Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6401 Loch Raven Blvd. 21239 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc ģ 1 Never Married 2 Married within 72 hours after Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) 12th Unemployed N/ABe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 ၉ Page 1 end 2 should be Rachael Jenkins Willie Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6016 Bell Vista Ave. Baltimore, MD 21206 Donna Lawrence-Daughter OCTOBER 28, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/7/2012 OwingsMills, MD Garrison Forest March F/H-East 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Records, P.O. Box 68760 After this certificate hes been signed by the attending i funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown HELEN PRICE Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 2 😿 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Acciden
Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP 31. Date filed (Month, Đay, Year) State

DHMH 17 Rev 06-2011

Registrar

NOV O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Year Nov Physician/ \mathbf{A}^{M} 5:45 Thelma Louise Power Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Westminster Dove House If Under 1 Year If Under 24 Hrs.
Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth Funeral (Month, Day, Year 1/14/192 1 □ M 21€3€ VA 214-18-1400 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2XXNo 28a-f MD Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number b 23a Funeral 4417 Buffalo Rd. USA 21771 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Was Decedor... Armed Forces? - Ves 2XXNo Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3XXVidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Dept. of Motor Vehicles unknown Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ollie Gray Maddox Charles Richard Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buffalo Rd., Mt. Airy, MD 21771 Brenda Daniels 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem. 11/6/2012 Baltimore, MD 21. Signatury of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for es a nonsectionne offi-Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 <Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) Pregnant at time of death ed by the detached Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accide injury 5 Pending Accident Investigation Suicide 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours after death.

To the Funeral Director; After this certificate filled in by the

> State Registrar

Medical

29a. Certifier

(Check

only one

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ October 7:30 William Curtis Powell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Westminster Dove House Birthplace (State or Foreign Country)
 MD 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Months Min. 1 🔀 M 2 🗆 F 6 7 25 7 1 9 24 88 **Director** 208-16-5797 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If firen 27 is marked other than "natural". or item. not any injury or other trainment. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No MD Carrol1 Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21771 United States Funeral 201 Watersville Rd. APT 46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 1942— Black, White, etc 1 Never Married 2 K Married ð Specify: White ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Millwright Scott Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unknown Maiden Ress Maurice Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Watersville Rd. APT 46 Mt. Airy, MD 21771 Shirley Avery Powell (Wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11/1/2012 Winfield, MD 4 Donation 5 Other (Specify) S. Carroll Crematory 22. Name and Address of Facility Burrier-Oueen Funeral Home and Crematory. 1212 W. Old Liberty Rd. Winfield, MD 21784 mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on ach line Interval Between nset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? page 2 should be detached for Day 5 Other (specify) the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) the funeral director. 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 1 Yes 2 140 ER/Outpatient 3 DOA မ 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Certificate: 5 Pending work Natural 1 🗌 Yes 2 🗎 No after death. Director: Af Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only on 29b. Signatu 29d. Date signed (Month, Day, Year)

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State

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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kenneth Lane Prestia Month 30/2012 11:38a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Richey Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/27/1938 Funeral Birthplace (State or Foreign Country) 577-50-1089 Director 1**X**□ M 2 □ F 74 UNK 10b. County filed within 72 hours efter death with the Meryland other than "netural", or items 23e or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Fairfax VA Alexandria 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3709 Mark Drive 22305 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 5 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hotel Security Security Be 17. Father's Name (First, Middle, Last) permit. Pege 1 and 2 should be filed Department of Heelth and Mentel Hy Important: If Item 27 is marked ott any Injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Headquarters Dr Millersville MD 21108 Elaine Curl Auth Agent 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 11/01/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD lone 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as con liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or: After this certificate hes been signed by the ettending physicien end the funeral director, pege 2 should be deteched for use es the buriel-tren that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month 4 Pregnant a 9 Unknown Pregnant at time of death Day 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co, bute to the cause of death? Be Completed by Records, 1 Tyes 2 № o 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospitel or Attending Physician: 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specif 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation the Funeral Direc. 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical To the Hosp within 24 hou To the Fune completely fi 29a. Certifier 1 Kennying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Registrar State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM# | perPHys. #20b, perFH, G933, 11/3/2012, ws
State of Maryland / Department of Health and Mental Hygiene For State Registrar 35359 Certificate of Death Reg. No. 2. Date of Death Dejedent's Nerge (Firsp Middle dest) 7:30 a м Physician/ Junnita 1 Onth 1 Žear **3**¹¹³ Medical 4a. Facility Name (if not institution, give street and number) 2805 W. Mulberry St. 4c. County of Death Examiner 4b. City, Town, or Location Baltimore 7. Age (In yrs. I 74 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 216-36-9203 **Funeral** Country) Months Days 1 🗆 M 2 🔀 F Hours Min. 12/2/37 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show 10c. City, Town or Location
Baltimore 10a. State 10b, County 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD N/A 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 2805 W. Mulberry St. 10f. Zip Code 21223 Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? African Specify Amer. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) City of Balt. College (1-4 or 5+) Manager Be 17. Father's Name *(First, Middle, Last)* **Frank C. Starkes** 18. Mother's Name (First, Middle, Maiden Surname)
Doris Gatling 19a. Informant's Name/Relationship (Type, Print)
Maria Pierce/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 W. Mulberry St., Balt., MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Balt. Cty, MD 11/6/12Western Cemetery King Mem Pk 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FacilitHari P. Close F.Svs PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Failure TO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral invest of page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of VASCUlar 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 X No ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) yeurs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4pme ew! 31. Date filed (Month, Day, Year) NOV 0 5 2012 32. Registra s Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last, 3. Time of Death Physician/ Kobinson 2012 Medical 4a. Facility Name if not institution, give street and number, 4c. County of Dea 4b. City, Town, or Location of Death **Examiner** Bal ellivemate 8. Date of Birth 9. Birthplace (State or Foreign Age **Funeral** Min. **Director** 89 1923 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State must be notified at Director 1 🗌 Yes 2 💢 No 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any nigury or other traumatic event, the Market Funeral USA 21108 Was Deceas... Armed Forces? Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Specify: American 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Unemployed Be 18. Mother's Name (First, Middle, Maiden Surname) Un Known 17. Father's Name (First, Middle, Last) Willaber ည 19b. Mailing Address (Street and Number or Rural Route Number, City of own State Zin Code 9a. Informant's Name/Relationship (Type, Print) Dr. Hinesville, GA Ossa baw 2007 Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last signed by the attending physician Id be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Dav 1 ☐ Yes 2 2 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 No Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been significant to the Funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🔀 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending work? Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated **XCertifying Nurse Practitioner**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) attomosville 31. Date filed State NOV 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JACQUELINE ANNE REGLER October 31, 2012 5:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Th Months Hours (Month, Day, Year) Days Director 182-22-9076 1 🗆 M 2 🕱 F 315 March 27, 1929 PA Usual Residence of Deceder 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director MD Worcester Ocean City 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 107 Convention Center Drive 21842 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2XXNo 21215-0036 1 ☐ Yes 2XXXNo Specify: White 3 XVidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager K-Mart Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Costello Anna Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Haag / Daughter 711 Kirkcaldy Way, Abingdon, Maryland 21009 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of Important: If I eny Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA 11/9/2012 Ownings Mills, MD Signature of Fundre Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Ai 610 West MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) rial Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospitel or Attanding Physician: The law requires that the death certificate be executed 44 hours after death. Funerel Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) ☐ Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24 hours after deam.

e Funerel Director: After this certificate has occurate history filled in by the funeral director, page 2 should be one Dulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown ancurysm, chronic kidney disen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy III Stage sinus syndrome 1 Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical BB 26. Place of Death (Check only one) 2 🗹 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi Defining Prinstoan: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DCO59387 11-01-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aly Naguib 2 Colgate Dr. Suite 103 Forest Hill MD 21050 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 30 Physician/ Month 1 0 Lona Rae Rhoades 11:30p^M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 10/17/1961 Months Country) Director 213-84-9056 1 M 2X F 51 MD 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore MD Gwynn Oak 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21207 USA 2006 Gwynn Oak Averue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mentai Hygiene. Important if item 27 is marked other than any Injury or other trainment. College (1-4 or 5+) Elementary/Secondary (0-12) Kaiser Permanente Supervisor 4Yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph H. Rhoades Raella Emmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raella Rhoades (Mother) 5609 Groveland Ave. Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/9/12 Baltimore, MD Arbutus 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Brown Funeral Home PA 2140 N. Fulton Ave. Balto., MD 21. Signature of Funeral Service Licens 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-Sma Physician/ montres ease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 use as t y the attending p ched for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year 4 Pregnant at time of death 9 Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{VJSOLGE} \) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) OCTOSES

Registrar

N

horres

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

32. Registrar's Signature

CAMURS

31. Date filed (Month, Day, Year)

NOV 0 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 30 Month 10 Rehak Physician/ 11:40 thew Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville Oak Crest Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) 723-14-7315 Director 1 🔀 M 2 🗆 F 83 1929 Maryland April 24, Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Modical Examiner must be notified at 10b. County Director 1 Yes 2 X No Parkville Baltimore MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 SOS 10/30/30/30 Baltimore, Maryland 21215-0036 USA Funeral 21234 8820 Walther Blvd. #4105 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ş 1 ☐ Yes 2 X No Specify: 3 V Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Hospital Clinical Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Doyle Anna M. Rehak J. Matthew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Rehak/ Son 4419 Carlyn Rd. Perry Hall, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. **:11-3-12** ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Fureral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ MaHhと
Wehak
Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🔣 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🏂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) H0052365 10-30-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walther Boulevard, Parkville, Maryland 21234 8800 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 ctober 530 Physician/ Smith S. Gladys 2012 Medical 4a. Facility Name (If not institution, give street and number 4b City, Town, or Location of Death 4c. County of Death Examiner Maryland Greneral Date of Birth (Month, Day, Year) Social Security Number 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Funeral Hours 240-70-6382 1 □ M 2 🛣 F Director NC 02 42 Yrs 70 28a-f show 10d. Inside City Limits 10c. City, Town or Location aţ 10a. State 10b. County Director must be notified 1 XYes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 0 U.S.A. 23a 21229 124 South Culver Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4X Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 16b. Kind of Business/Industry Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5yrs+ Elementary/Secondary (0-12) Public School Sys. 12th grade pecial Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lela Idell Smith George Stanely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21229 Chanel Randolph-Grand 124 South Culver Street, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State 11/9/2012 Tabor City, NC Smith Family 4 Donation 5 Other (Specify) 21. Signature of Meral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause each line.

Cause (Final Approximate Interval Between Onset and Death Shock Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami neumonia and Due to (or as a consequence of): resulting in death) Last burialphysician 1 raci Physician/Medical P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the at d be detached f 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 has certificate or Attending Physician: 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after within 24 hours a

To the Funeral D

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who complete 28a) (Type, Print) Registrar's Signature 31. Date filed (Month, Dav. Year) State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Richard Sauers octobe 31 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Square oseda tranklin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 □ F Months Days Hours Min Director 215-28-7927 Sept. 16,1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examit or must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9012 Lennings Ln. 21237 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 뗏Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages † and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Rea1 Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Sauers Helen Caroline ည Max Popiacki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages † and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Patricia P. Sauers/Wife 9012 Lennings Ln. Baltimore MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 11/05/2012 Baltimore 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd. 21. Signature of Funeral Service Licensee MD 21236 Nottingham 23a. Part 1. Enter the disease, or shock, or heart failure List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** ard disease or condition resulting in death) /Medical Due to (or as a consequence): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performed 2 12 No 1 □ Yes □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after decrain Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29a. Certifier

(Check only

29b. Signature and tipe of

31. Date filed (Month; Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hempe

Year)

9000

Medical

completely

within 2

1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Square Drive Baltimore MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PEGGY ARLENE SMITH OCTOBER 31,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. Director 1 🗆 M 2 🕱 F 9-21-1943 WEST VIRGINIA 214-40-7867 69 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State the Medical Examiner must be notified at Director 28a-f MD. BALTO. KINGSVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11202 TOWOOD ROAD 21087 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) TECHNICAL ENGINEER DEFENSE COMPANY 12TH Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSCAR E. SMITH HELEN M. THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAT MEOLA **PARTNER** 11202 TOWOOD ROAD KINGSVILLE, MD. 21087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ATLANTIC CREMATORY 11-3-2012 GLEN BURNIE, MD. 22. Name and Address of FaciliSCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property is presented by the attending physician and burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown To the Funeral Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes owe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 1 Yes 2 No Yes 2 å 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature and 29d. Date signed (Month, Day, Year) D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. * 4105, Balthwore, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 **Physician** 50 2012 NEVEMBE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Mir 1 X M 2 □ F 219-860-2560 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Examiner must be notified at 1 Yes 2 No Maryland Director MORE 10f. Zip-Code 10g. Citizen of What Country? et and Numbe ò Items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2/10 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 2 CHO Specify 1 Tyes <u>م</u> 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AWRENCE ပ္ Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 Cremation 20c. Location - City or Town, 21. Signature of Funeral Service Licers

22. Name and Address of Facility

23a, Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ZUVR days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 16 days Examiner tremens Irrival Sequentially list conditions, if any, leading to initraclate cause. Enter Underlying Cause (Disease or injury Examiner Dies to for as a consequence of use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 hknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The law after death.
Director: After this certificate has be 2 🗌 No 1 TYes Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 2,2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 v 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jeff	Robert	Schreiber	
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2012 3	35	3	5	(
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	1- For State Registrar		Certific	ate of De	eath			Reg. No.	20		
Physician	1. Decedent's Name (First, Min						2. Date of D	eath Day	Year	3. Time of Death	
Medical Examine	OCII	bert Schre	iber				Novem	November 2, 2012 1543 hrs			
	4a. Facility Name (if not instituted 14926 Nighthawk La			_	City, Town, or Lo owie	ocation of I	Death		f Death eorge' S		
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birt	_	Under 1 Year Ionths Days	If Under 2				Birthplace (State or Foreign	
Director	394-62-9324	1 X M 2 F	47	Min. 01	/05/	Country) WI					
h	Usual Residence of Decedent		10c. City. Town	or Location						10d. Inside City Limits	
Aaryland 28a-f show any 1 at once.		nce Georges	Toc. City, Town		Bowie				1 Yes 2 X No		
the Maryland a or 28a-f sh tified at one	10e. Street and Number			10	f. Zip Code			10g. Citi	izen of Wha	at Country?	
death with the Maryland or items 23a or 28a-f shomust be notified at once.		wk Lane			2	20716				USA	
h with	11. Marital Status 1 Never Married 2 X	12. Was Decedent Armed Forces?	Ever in U.S.				n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - White,	- American Indian, Black, , etc.	
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-1	2) College (1-4 or 5	+)	_					ont	of Defense	
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21215-0036 tould be filed within 7 d Mental Hygiene. is marked other than itic event, the Medica		nship (Type, Print)	191	o. Mailing Add	dress (Street a		-			n, State, Zip Code)	
MD d 2 sho lith and n 27 is	Diane L. Sch	reiber (spou	ıse) 1	4926 N	Nighthav	vk Lai	ne, Bowie	e, MD	2071	6	
Te, land I and Titem Titem	20a. Method of Disposition 1 Burial 2 Cremat	ion 2 Domoval from Sto		of Disposition ory or other p	(Name of ceme	etery,	Nov. 0	7		City or Town, State	
Pages tent of unt: I	4 Donation 5 Other		" Metro	Crema	atory Ir	nc.	2012	Daltimora Maryland			
Baltimore, permit. Pages I ar Department of Hec Important: If ite Injury or other tr	21. Signature of Funeral Servi	ce vicens+		22. Name	and Address o	of Facility	Stalli	ngs F	unera	al Home, P.A.	
	23a/Part I. Enter the disease,	/Stall-	1)] 3	3111 Mou	ıntai	n Road,	Pasad	lena,	MD 21122	
Physician Medical	failure. List only one cau	or complications that caused to se on each line.	the death, Do no	ot enter the m	lode of dying, st	uch as car	diac of respiratory	arrest, sno	ock, or nea	Between Onset and Death	
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760, cate be executed physician and the burial - transit	events resulting in death) Las		quence of):								
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b. Box 68' the death certification by the attending sched for use as	1 Yes 2 No 9 l	Jnknown 9 Unknown	ime or death	Other	(Specify)			1000			
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eco he law ite has							1 V Ye	erformed? es 2 N	de lo 1	eath? ✔ Yes 2 No	
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Physician this carral direc	1 🗸 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/O	utpatient 3	DOA	ther I	Nursing Home 5				
ing Pl		28a. Date of Injui (Month, Day,Ye		Time of Injury			28d. Descri	be how inj	ury occurre	ed	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Diversitian/Medical Expedical Control of the contr	3 Suicide 6 C	ould not be 28e. Place of Injectermined (Specify)	ury - At home, fa	arm, street, fa	ictory, office bui	ilding, etc.		n (Street a n, State)	and Numbe	er or Rural Route Number, City	
Di To the Hospital within 24 hours a Within 24 hours a To the Funeral I	4 Homicide 29a. Certifier 1 Certifying	Physician: To the best of my	knowledge de	ath occurred :	at the time, date	e and place	e, and due to the c	ause(s) ar	nd manner	as stated.	
To the Hos within 24 h To the Fun completely	(Check only one) 2 Medical E	xaminer:On the basis of exam and manner stated.									
Z : ½ 6 8	29b. Signature and title of cert		d		29c. License	number		29d.	Date signe	d (Month, Day, Year)	
	1061	111	1/	L	O.C.M	l.E.		Nov	vember 3	3, 2012	
	30. Name and address of pers										
	Zabiullah Ali, M.D.	Assistant Medical Ex		o W. Balti	more Stree	t, Baltim	iore, MD 2122	:3			
Stat Registra	FEE 4.1 A 8.21 482	32. Registrar	solgnature	bar	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 01 2012 0430 M Albert Shuster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 579-40-8812 1 X M 2 🗆 F Director 81 Yrs Maryland 09/14/1931 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 Yes 2 No 28a-f Silver Spring Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b ral", or items 23a or Examiner must be Funeral 20902 u.s.A. 911 Hyde Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify. 3 Widowed 4 Divorced Korea Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Food & Wine Retail Merchant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ida Silverman Isaac Shuster and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Hyde Road, Silver Spring, Maryland 20902 f Health a Ellen Shuster - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott once. 1 X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 11/05/2012 | Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licenses MD 0730 1800 New Hampshire Ave., Silver Spring, MD 20904 Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiogenic Shock disease or condition Medical resulting in death) **Examiner** Congestive Heart Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. tending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Acute Renal Failure page 2 should 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? 2 **X** No __ Yes 25. Was case referred to medica examiner? Be (26. Place of Death (Check only one) 1 ☐ Yes 2 X No ပ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

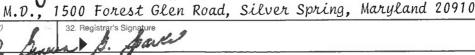
To the Funeral Director: After to ompletely filled in by the funer 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

XX

Registrar

Maria Tayag, 31. Date filed (Month, Day, Year)

only one) 29b. Signature



of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D63579

29d. Date signed (Month, Day, Year)

November 01, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2012 Clare Schu1z 06:09P M Regina Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE **Examiner** 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8 Date of Birth (Month, Day, Year) Days Hours Director 219-22-0255 1 M 2 X F 85 Nov 22, 1926 New York permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show my Injury or other treumatic event, the Medical Examiner must be notified at ones. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 💢 No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 21030 219 Wickersham Way USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Maryland 212 College (1-4 or 5+) 04 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reynolds, Sr. Regina Magdalene Hanley James Aloysius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Regina Pippin/Daughter Fork Road, Baldwin, Maryland Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/4/2012 Glen Burnie, Maryland of Funeral Service Lice 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley Inc. O W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. E er the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or healt failure. List only one cause on a chiline. Immediate Cause Final disease or condition resulting in continuous Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year TOWSOM, MI ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 3. Time of Death Physician/ NOVEMBER D 2012 12:35 AM Milton Sachse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BA
5. Social Security Number ${ t TOWSON}$ BALTIMORE MEDICAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) 1 X M 2 □ F Director 217-07-4894 92 Aug. 8, 1920 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Brightwood Club Drive 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 1943-1945 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Truck Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Sachse Marie Schmidt Α. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) Brightwood Club Drive Lutherville, Maryland Sachse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Dremation 3 Removal from State Hilltop Service Corp. 11-6-2012 4 Donation 5 Other (Specify) Towson Maryland on the effuneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 Bu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ umonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director. After this certificate has completely filled n by the funeral director, page 2 autopsy Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No |2 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) ō 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ouwe; MA MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day}, October 2012 1:32 Рм Ronald L. Schroyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Nursing Center Towson Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours Min (Month, Day, Year) Director 218-48-0269 1 😿 M 2 🗆 F Vre Usual Residence of Deceder 02/27/1948 Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tyes 2 No Dundalk MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 Louth Rd. 21222 USA within 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give
Year or Dates. Peacetime 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Construction Supplies Manufacturing event, Be permit. Page 1 and 2 should re filed Department of Health and Mental Hy Apportant: If Item 27 is merited oth any injury or other traumatic event ance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Younkins Betty L. Μ. Schroyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita L. Schrover (wife) Dundalk, Maryland 3420 Louth Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State
 □ Donation 5 □ Other (Specify) 11/01/2012 Glen Burnie, MD Haven Cemetery Ture of Funeral Service Liminsee Sign 22. Name and Address of FacilityDuda-Ruck Funeral Home of Dundalk, MD 21222 Dundalk, Inc. 7922 Wise Ave. Fart 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cell IUNS Nonsmall disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 24 hours after death, Foundation of the aspensioned by the a retely filled in by the funeral director. After this certificate has been signed by the atetached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No nospice မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or inventioning in any spirited in the cause of examination and/or inventioning in the cause of the cause of examination and/or inventioning in the cause of the cause of examination and/or inventioning in the cause of the cause of examination and/or inventioning in the cause of Medical 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29c. License numbe OCTUSE 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 HANDN 31. Date filed (Month, Day, Yea 32. Registrar's Signature State

Registrar

NOV U 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0920 A M Julia Frances Simmons NOV 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore HOSPITA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 26, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Virginia Months 1 M 2 TxF 216-24-6592 82 1930 Aug. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expression rust be mailined at Completed by Funeral Director 1 □ Yes 2 🙀 No MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 305 Osborne Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. Iem 27 is marked other than College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Bolton** Shifflett Benjamin Henry Nellie Frances ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James A. Simmons (Husband) 305 Osborne Ave., Baltimore, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/12 Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** MW ON Securificity list con flions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): as the burial-transit resulting in death) Last Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be spital: rule Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
28c Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No Certification: To o 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ō 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q SAMBANDAM WILKENS 31. Date filed (Month, Day, Year) State 0 5 2012 Registrar

Simmons

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20/2 1820 M Sesplankis 0 JoAnn Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospita Talbot Easton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours 214-24-7712 Director 1 M 2 X F 3/29/28 Pennsylvania Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28e-f show eny Injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 715 Maiden Choice Ln. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 K Married 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Travis Brill Oscar Sesplanki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Ln., PV 507, Catonsville, MD. 2122 Daniel J. Sesplankis (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/3/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Nother (Specify) Entombment 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Physician/Medical Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Renol Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bochevaria 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 2 TN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA |은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No 14 Natural 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death page and the cause (s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P\$\$59762 10/31/2012 10 ph 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eostm, MD 21601 tof 31. Date filed (Month, Day, 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Physician/ Month SCHAEFER 242 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER ANNE CLEN BURNIE ARUNGEL 9. Birthplace (State or Foreign Country) England 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 3/27/28 218-36-1816 1 🗆 M 2 🕇 F Director 84 Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Linthicum 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 426 Sudbury Rd. 21090 United Kingdom or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White than "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Stephen Alphey Lillian **Blanche** Atwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 and 2 s Health a James J. Schaefer (Husband) 426 Sudbury Rd., Linthicum, item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 20a. Method of Disposition Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 11/3/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore MD 21229 23a, Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician, HNEWWORLIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 certificate 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 🗀 No ည 1 Inpatient 2 NjER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 \square Pending Natural Accident Investigation 6/23/12 MINONN M ELL IN KITCHEN the. 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completely filled in by determined building, etc. (Specify) 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

5

BLEN BURNIE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 SUSANN DOROTHY SILVERMAN OCTOBER 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6350 RED CEDAR PLACE, BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 219-12-6972 1 M 2 X F 89 07/23/1923 PA Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, tr.e Medical Era niner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6350 RED CEDAR PLACE, #201 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian and Mental Hygiene. is marked other than "naturai", or i Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JACOB NAIDITCH IDA KENIG t. Page 1 and 2 should by thent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE SILVERMAN/DAUGHTER 6350 RED CEDAR PLACE, #201, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State Injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2012 BNAI ISRAEL CONG. BALTIMORE, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on Lagues on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dementes disease or condition years Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): nding physician and use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year ete has been signed by the appropriet propriet propriet pege 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificete Yes 2 No efter death.

Director: After this certifice d in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes ဠ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours e Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Completely 2 Gettiying Firstcari. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu

68M

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

NOV U 5 2012

DHMH 17 Rev 06-2011

W557

sulella

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

ROSENBERG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of	Marylan		artment of F <i>tificate of L</i>	Health and N Death		C 0	12	35377
			Registrar 1. Decedent's Name (First, Middle	e, Last)			tineate of E	Jean	2. Date of Dea	Reg. No. th		3. Time of Death
Physic Med		_	JUDITH	CLARA		SHUST	'ER		OCTOBE1	R 30 20	12 Year	04:00A M
Exam		-	4a. Facility Name (if not institution	n, give street and numb	4b. City, Town, or	r Location of Death		4c. County	of Death			
<u> </u>			SPRINGHOUSE AS 5. Social Security Number		VING 7. Age (In yrs. Is	ant hirthdayl	PIKESV If Under 1 Year	ILLE I If Under 24 Hrs.	8. Date of Birth		TIMOR	
Funer: Directo		ı,	214-22-0400	1 M 2 X F	. Age (III yis. II	Vre	Months Days	Hours Min.	(Month, Day		9. Birtinp Count	lace (State or Foreign ry)
8			Usual Residence of Decedent			85			09/16	/1927		NY
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death items ner mi			11. Marital Status	12. Was Deced		5. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Rac	e - America	
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hours natura ical E		Completed	15. Decede	ent's Education	es.	16a. Deced	dent's Usual Occup	ation		16b, Kind of B	WILL	
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be filed antal Hy ked out		9	17. Father's Name (First, Middle, ALBERT	Last)	1	MANDEL1		18. Mother's Nam	ne (First, Middle, I			RSTEIN
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Ite, INIAL YIAITU ZIZIOUOOO 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at			STEVEN L. SHU	STER/SON		13	GRANARY	DRIVE, PI	KESVILL	E, MD 2	1208	
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it. Page 1 rtment of rtant: If it			4 Donation 5 Other (Specify)			ER WOLIN		2/2012		IMORE	
permit. Page Department of Important: If any injury or	ouce		21. Sign (ure) Funeral Service	_icenspee		22		ss of Facility SO STERSTOW				INC. MD 21208
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Atter er deg rector by th	19	cer unicate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place o	of Injury - At ho g, etc. (Specify		eet, factory, office		28f. Location (Si		er or Rural	Route Number,
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after datathin physician: The law requires that the death certificate the Euheral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Andio	Medical	(Check 2 Medical I	g Physician: To the bes Examiner: On the basis g Nurse Practitioner: 1	of examination	n and/or inves	tigation, in my opinio	on, death occurred a	it the time, date ar	nd place, and du	e to the cau	ise(s) and manner stated.
To the vithing some	-		29b. Signature and title of certifie	20			29c. License	e number	2	29d. Date signe	d (Month, E	Day, Year)
11/04			Jaran 186	es mo			DOC	061199		UCT, S	0, 7	0/2
Tolly			30. Name and address of person Saron Black	who completed cause MJ,6701	of death (Item	123a) (Type, F 2 (4a	rint) rles St	· Suite	1105,70	ouson	MD	2/204
S Regis	tate trar		NOV U 5 2012	Deneur)	gistrar's Signar	arking .			(

12-08105 Bertha Mae Taliaf	erro			pe or Print ate of Mary		/ Departme	nt o	f Health	n and				egib.	le. 20	12	35378
		- For State Registrar				Certifica	te o	f Death					Reg. N	100	1 644	
Physiciar Medical Examin	n/ er	1. Decedent's Nam Bertha		Δ	Mae Taliaferro							2. Date of D Month Octobe		Year 012		3. Time of Death 1015 hrs
~		4a. Facility Name (on, give street and	number)			4b. City, To Baltim	-	ocation o	of Death			4c. County of	Death	
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ore, es lar of Heg of Heg		20a. Method of Dis 1 🙀 Burial 2		n 3 Removal	from Sta	20b. Place of cremato		ther place)	e or cemi						tion - City or Town, State	
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ox 68760, sath certificate be ex attending physician for use as the burial.		IF FEMALE:			s, outcor	me of pregnancy							- 1:	23d. Date of d	elivery	
Box 68760, seath certificate be the attending physic defor use as the burner	ian/	23b. Was decedent past 12 month:		LIV	Program of time of								ay Year			
Sox feath ge atter for us	Sic	1 Yes 2 🗸	No 9 🔲 Ur	des		time or 5	C	ther (Speci	fy)							
that the de detached f		Part II. Other sign	ificant condi	tions contributing	to deat	h but not resulting	in the	underlying	cause gi	ven in Pa	art I.	23e. D	id tobac	co use contrib	ute to t	he cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirers after death. Tal Director: After this certificate has been sited in by the funeral director, page 2 should be in the funeral director.		1 Natural		(Mo	ite of Inju	rear)	inie oi	injury 2		es 2		Zou. Desci	ibe now	injury occurre	u	
isio	<u>cat</u>	2 Accident	Inve	estigation 28e P	ace of Ir	njury - At home, fa	rm, stre	eet, factory,	office bu	ilding, et	tc.	28f. Locatio	on (Stree	et and Number	or Ru	ral Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Directors	Certification:	3 Suicide 4 Homicide		old not be ermined (Speci	fy)						l	or Tow	n, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial -	edical C	29a. Certifier (Check only one) 2		Physician: To the laminer: On the bas	is of exa											
E 3 E 8	₹ E	29b. Signature and	title of certif					29c.	License					d. Date signe		
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Registr	1.7	NO	V () 5 2	012 Sen	ww	p. 19	ICINI									

12-08203 Lenora Taylor Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend # State of Maryland Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of Death		riggione	201	2 3537
Physi Medical Exa	icia: min	/					2. Date of D		3. Time of Death
		4a. Facility Name (if not institu	lay/or				Month October	30, 2012 Year	0938 hrs
		Sinai Hospital	mon, give street and number)		4b. City, Town Baltimore	, or Location of De	eath	4c. County of De	eath
Funera	al	5. Social Security Number	6. Sex 7. Age	(In yrs. last bird					
Directo)T	217-86-1308	1 M 2 V F		Mantha		Min. I	Birth(MM/DD/YYYY) 9.	reian
	7	Usual Residence of Decedent			2 Yrs. Wortths L		3-3	3-1970	Country) MD
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Mary 28a-		10e. Street and Number	1	\mathcal{O}^{q}	10f. Zip Code	e		10g. Citizen of What Co	
with the Maryland us 23a or 28a-f sho	2	4922 Lite	hfield Ave	nile		21216			-
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mennal Hyggene. 27 is marked other than "natural", or items 23a or 23a-f she make event, the Medical Examiner must he notified as one	Finars	11. Marital Status 1 ✓ Never Married 2	12 Was Decedent Ev	ver in U.S.	13. Was Decedent of	212-15 Hispanic Origin? (Specify Yes or N	U5/	erican Indian, Black,
er dea	ة	Never Warried 2	1 Yes 2	No	If Yes, specify Cub	oan, Mexican, Pue	rto Rican, etc.)	White, etc.	erican indian, black,
5-0036 lied within 72 hours afte Hygiene, other than "natural", the Medical Examiner	2	15.0	livorced If Yes, Give Year or Dates:		1 Yes 2			Specify: B	lac K
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2121; ould be fil Mental F marked	B B	James E.	TaylorSo			To. Wotner's Nan	ne (First, Middle,	Maiden Surname)	
ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other in natic event, the Med	P	19a. Informant's Name/Relation	ship (Type, Print) / Fat	ther 19b.	Mailing Address (Str	eet and Number of	Philippe Rural Route Nui	mber, City or Town, Stat	7
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Baltimore, M bernit. Pages I and 2 bepartment of Health; important: If iten 2;		20a. Method of Disposition 1XX Burial 2 Crematio	n 3 Removal from State	20b. Place of cremator	Disposition (Name of c y or other place)	emetery	Date 4014	Finore M 20c. Location - City o	r Town, State
Lim Pa men tant		4 Donation 5 Other S	Specify:	MT.Zio	on	11	/16/2012	Ballim reene Finer	a
Balti permit. Departu Importa		21. Signature of Funeral Service	Licensee		22. Name and Addres	ss of Facility	cha C G	La Jym	ore mo
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/Medical		23a. Part I. Enter the diseas or failur. List only one cause	complications that caused the on each line.	death. Do not	enter the mode of dying	, sur las cardiac	respiratory arr	est, shock, or heart	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death)		e Cardi	ovascular	Disease			Between Onset and Death
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8760, ifficate be ex ng physician as the burial.	Me	IF FEMALE:	220 16 100 - 1		78	3 13 Om			
certifi nding se as	ian	23b. Was decedent pregnant in th past 12 months?	e 1 Live birth	2	Fetal death 3	Ectopic pregna	ancy	23d. Date of delivery Month	
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tal Records, P.O. Box 68: cina: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as t	됩	Part II. Other significant condition		not resulting in	the condent is				1
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		Theodore M. King, Jr., N			900 W. Baltimo	ore Street, Bal	timore, MD 2	21223	
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		4	State of Maryland / Department of Health and Mental Hygiene 2012 35380 Certificate of Death Reg. No.							
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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC, 9705 BELAIR ROAD NOTTINGHAM, MD. 21236							
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	F S F O		* (Kant 1) ANP-BC ROSG520 November 2 Dur							
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
<i>b</i>			Month ANP-BC RO86520 November 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karan Jenning 6095 Marshalee Drive Elkridje Md. 21077							
)	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2012							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35382 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012^{xear} Uchuck November 12:25 AM V. Fmma Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Báltimore Lutherville 1405 Warwick Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) 217-03-9460 Director 1 □ M 2 🖔 F 93 Aug. 14,1919 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 1405 Warwick Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Camillo Vanni Maria DiGiovanni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Mazzotta Daughter 6904 Harewood Road Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Dudenties verewaterly prother place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 11-8-2012 <u>Timonium</u> Maryland Ruck Towson Funeral Home, Inc. 21. Si nature Funeral Service I censee 22. Name and Address of Facility 1050 York Road Towson, Maryland agai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE ITEMAT OYEMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Auno STENUSL Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit MOION 13cltém に that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ANTENED SCLEADIL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 111 2112 D0628812 30. Narrie and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Vincent Dipietro

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31. Date filed (Month, Day, Year)

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7801 York Rd Towson, MD

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 Mary Month **Physician** Whitehead 2012 (0107 AM actober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. 74 212-34-2038 Director 10/31/1937 VA Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Xves 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3420 E. Baltimore 21224 Funeral 12. Was Decedent Ever in U.S Armed Forces? items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 X No Black þ Specify: 3 XWidowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 9th N/A Disabled N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Scott Dorothy E. Williams ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is 3420 E. Baltimore St. Baltimore, MD 21224 Arthuretta Jones-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 11/1/2012 Baltimore. March F/H-East 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1. M. The 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory //Medical Due to (or as a consequence of): **Examiner** ASCVO iony stand, un Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specity) Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No မ

Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. certificate has After this

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Baltimore, Maryland 21215-0036

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Hardin 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Pantle, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

October 25, 2012

State NOV 0 5 Registrar

29c. License number

D-0061115

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V vith	29b. Signature and title of certifier	Payrel		9c. License number 130/2	2	29d. Date signed (Mon	ith, Delf, Year)		
K	30. Name and address of person who	completed dause of death (Item	n 23a) (Type, Print)	Jos St.	BJ/10,	Md 2	2/8		
State Registrar	NOV 0/6 2	U12	B. park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 35385 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 2.9 Day 5:05 AM Algeane Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Hours (Month, Day, Year) Director 219-32-9590 Usual Residence of Deceder 1 M 2 X F 74 4/26/1938 MD ed other than "natural", or items 23a or 28a-f show event, tre vectoral Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Baltimore 1 X Yes 2 ☐ No MD N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21213 1756 Darley Ave. USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Election 12th Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Is marked o Department of Health and Department of Health and Menta Important: If item 27 is marked any injury or other traumations. မ Patrick Tucker Marv Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Vernetta Owens-Daught 2913 Glendale Ave Baltimore MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Memorial Pk. 11/3/2012 Randallstown, MD King 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ancient Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury as the burlal-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burlal-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year 4 Pregnant at time of death 9 Unknown ate has been signed by the a page 2 should be detached to 9 Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy
performed?

Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 XNo Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOS ALCO 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death ordinal at the time, date and place, and flue to the cause(s) and marrier as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aron N Charles ALIES 5701 31. Date filed (Month, Day, Year,

Registrar

5 201

NOV 0

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:40A M 10 Medical Name (if not institution, give street Examiner 15ing Home Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F 16 **Director** a or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ✓ Yes 2 ☐ No timore 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done life, DO NOT use retired most of working nday (0-12) College (1-4 or 5+) Be ather's Name (First, Middle, Last permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (N 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Brona disease or condition resulting in death) Medical Due to (or as a consequence o **Examiner** Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Succeeded at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has k
completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4-Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1/K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 7543 10-31-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) METINDER 1940 W, BALTINULE ST. BALTIMURE MO21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08:30 AM WENCZKUWSKI IRENE LIZABETH NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Care Center Baltimore Baltmore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 M 2 K 70 Months (Month, Day 214-40-08 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ♠ No
If Yes, Give 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry State FARM INS Elementary/Seconday (0-12) College (1-4 or 5+) Secretar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FANK 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) MD 2123 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 21. Signatur neral Selvice Licensee use se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Fi Onset and Death Physician/ annhythmia disease or cond tie resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury bitructive sulmonary Hospital or Attending Physician: The law requires that the death certificate be executed Chronic After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Incomment of the function of t 1 ☐ Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier November 2, 2012 ress of person who completed cause of death (Item 23a) (Type, Print) d C 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend 17, per 1h, 8933 11-26-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Marjorie B. Walters 2012 8:42 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 05/20/1923 New York Days Hours 065**-**14-6295 89 Director 1 M 2 X F Yrs Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Baltimore Parkton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21120 & Twins Oaks Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Special Education Teacher Education 5+ Be 17. Father's Name (First, Middle, Last) Harold Walton Barnett 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ethel Hess H. Walton Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Bostwick Lane Gaithersburg, Maryland 20878 19a. Informant's Name/Relationship (Type, Print) Jennifer Miller 20b. Place of Disposition (Name of cemetery, crematory or other place Fairview Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11/10/2012 Amsterdam, New York 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Muta Starre Cana disease or condition resulting in death) へいっけん Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the buriel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been signirector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence <u>|</u>2 1 🗌 Yes 2 X)No 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifie 29c. License number 29b. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORA 100 31. Date filed (Month, Day, Year) 32. Signature State NOV 0 5

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Clarence W. Albright Jr. Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Cumberland Western Maryland Health System If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral Social Security Number 7. Age (In yrs. last birthday) Director 212-24-4819 1 ₹ M 2 □ F 81 June 14,1931 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location Completed by Funeral Director Meyersdale Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 15552 117 Olinger Street "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Law Enforcement 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Bryan <u>Clarrence W. Albright Sr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Olinger St., Meyersdale, PA 15552 Betty Albright/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Greenville Union Ceme: 10/27/2012 Meyersdale, PA 21. Signature of Funeral Service Licensee CC0376 22. Name and Address of Facility W.R. Price Funeral Home, Inc. 325 Main St., Meyersdale, PA 15552 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardine disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death signed by the at Id be detached for 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

3. Time of Death

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗌 No

Year

1X Yes 2 ☐ No

Box 68760 P.O. Records, Hospital or Attending Physician: The Division of Vital To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 00051379 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMS RU CUMBERLAND MO THOMAS GHOBRIAL 10 12252 31. Date filed (Month, Day, Year) OCT 2 4 2012

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Mary Registrar		tificate of D			eg. No. 🤈 🕦	1.0	2520
Physicia Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Martha Adams		-		2. Date of Deat Month	Day	Year	3. Time of Death 0635P
Exami		4a. Facility Name (if not institution, give street and number) Somerford Place		4b. City, Town, or L	ia		4c. County of Howa		
Funeral Director		5. Social Security Number 076-30-3824 Usual Residence of Decedent 6. Sex 1 □ M 2X F	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 4/28/1	Year)	9. Birthpl Counti	•
ryland -f show ied at	ctor	10a. State 10b. County 10	c. City, Town or Loc					10	d. Inside City Limit
th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number	Ellicott	10f. Zip Code 21043		1	10g. Citizen of W		ry?
after death wi ", or items 2 caminer mus	by	4951 Bramhope Lane 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ ★No If Yes, Give		Vas Decedent of His Yes, specify Cuban		cify Yes or No- Rican, etc.)	14. Race Black	- America , White, e	n Indian,
is filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Year or Dates. Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k life. DC	lent's Usual Occupat kind of work done du O NOT use retired)		ng	16b. Kind of Bu		ustry '
I be filed within lental Hygiene. rked other than tic event, the M	To Be C	17. Father's Name (First, Middle, Last) John M. Delavan	1.6	eacher	18. Mother's Name	(First, Middle, N			A
1 and 2 should be file of Health and Mental H Item 27 is marked o other traumatic eve	(1)	19a. Informant's Name/Relationship (Type, Print)	11	g Address (Street ar				ate, Zip C	ode)
		1 Purial 2 Transition 3 Permayal from State	20b. Place of Dispos cemetery, crem Crem. Cen	sition (Name of natory or other place ter of MD	10-20	Date 0-12	VA 22203 20c. Location - City or Town, State Hanover, MD		
permit. Page Department of Important: If any injury or	59	21. Sign rure of Funeral Ferrice Lice see	tzke's icott C	Famil ity,	y FN Inc MD 21043				
Medical Examiner the private physician and the burial-transit the burial-transit		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co	onsequence of):	5 D14	Sease				Interval Between Onset and Death 2 Y ewc
e deatn cerumcat the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of deliver	y Day Year
Attending Friystoan: The law requires that the death certificate be executed at death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Ph	Part II. Other significant conditions contributing to death but n	ot resulting In the ur	nderlying cause give	en in Part I.	1 Ye	es 2 No :	3 ☐ Prob	e cause of death? ably 4 Unknowsy findings available pletion of cause of the cause
ysician: The is certificate director, pag		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	_ Other	ce of Death (Check		ince 6 X Other	(Specify)	A-45isted
death. tor: After thi the funeral	Certificate: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Ye) 2 Accident Investigation 3 Suicide 6 Could not be	28b. Time of injury	28c. Injury : work? M 1 \square	at 2 No	28d. Describe ho	w injury occurred	d	
e nospiral or Attendin 124 hours after death. e Funeral Director: Aft letely filled in by the ful	Medical Cert	4 Homicide determined 28e. Place of Injury building, etc. (S)	pecify)			28f. Location (Str City or Town	, State)		
A U W	15	(Check 2 Medical Examiner: On the basis of exam	ination and/or investi	igation, in my opinion	i, death occurred at	the time, date and	d place, and due	to the caus	se(s) and manner st
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	only one) 3 Certifying Nurse Practitioner: To the be	MD	29c. License i			9d. Date signed		

· Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 14 2012 OLINDA VIEIRA ALVES 12:25P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days (Month, Day, Year) Min. Director 164-54-7486 1 DM 2 X F 26,1942 Portugal Usual Residence of Decedent "natural", or itama 23a or 28a-f show idigal Exeminer must be notified at 10b. County 10a. State filad within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5797 Western View Place 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ₭ Widowed 4 ☐ Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sewing 12 Seamstress permit. Paga 1 and 2 should be filad w Department of Haalth and Mantal Hygi Important: If Itam 27 is markad othe any injury or other traumatic evant, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Berta Mendes Vieira Jose J. Lourenco Alves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5797 Western View Place, Mt. Airy, Maryland 21771 Anabél Fink / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State netery, crematory or other place) 10/19/2012 Saint Mary's Cemetery 4 Donation 5 Other (Specify) Mt. Emmitsburg, Maryland. . Signature of Funeral Service Liver 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ *letastatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner astat Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of inding physician and use as the burlal-transit that the death certificate ba executed Due to (or as a consequence of): resulting in death) Last ate has been signed by the attanding physician page 2 should be detached for use as the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes 2N No Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Pl within 24 hours after death. To tha Funeral Director: Aftar th completaly filled in by the funera 28b. Time of Certificate: 28d. Describe how injury occurred Aftar Natural 5 Pending iniury Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

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		For State Registrar				tificate			_	Reg. N	201	2 3539	2
Physicia Medic		1. Decedent's Name (First, Middle, Le Sheila Keena	Andrews						2. Date of De Month October		ay 2012 Year	3. Time of Death 0614 M	Λ
Examin		4a. Facility Name (if not institution, given Kline Hospice					Town, or L	ocation of Death			c. County of D	eath lerick	
Funeral Director		579-40-0077	Sex 7. Ag	e (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 10	ay, Year)	(Birthplace (State or Foreig. Country) celand	n
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	ector	Usual Residence of Decedent 10a. State 10b. County Freder:	ick		y, Town or Lo			-	l <u>.</u>			10d, Inside City Limits 1⊠X Yes 2 □ N	
	neral Di	10e. Street and Number 2470 Five Shill:	ings Road			10f. Zip	Code 2170	1		10g. C	citizen of What	Country?	
rs after deatl ural", or iterr Examiner n	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	12. Was Decedent Be Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		1		ify Cuban,	Mexican, Puert	oecify Yes or No- o Rican, etc.)		14. Race - Ar Black, W Specify:	merican Indian, hite, etc. white	
within 72 hou giene. er than "natu the Medical	Completed	15. Decedent's (Specify only highest of Specify only highest of Specify only highest of Specify (0-12)	life. D		k done du retired)	ion ring most of wor	rking		Kind of Busine	•			
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nd 2 should ealth and N m 27 is ma		19a. Informant's Name/Relationship							ral Route Numberubusco,			Zip Code) 12923	
Page 1 ar		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Spec		C	Place of Dispo emetery, cren klawn	natory or o	ther place)		Date 20-2012			or Town, State Maryland	
permit. Departr Importa any injt		21. Signature of Funeral Service Lice	nsee	ue					auffer ike, Fr				0'
Physician/		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused one cause on each line META	Э.				such as cardiac		rest,		Approximate Interval Between Onset and Death MoNTHS —	
Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions,	Due to (or as a									YEARS	
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ite be exe hysician a ihe burial-	_ ı												
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial production.	Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of Month	delivery Day Year	
ires that th signed by Id be detac		Part II. Other significant conditions 1. DEMENTIA	contributing to death b	ut not res	ulting in the u	nderlying o	ause give	n in Part I.				to the cause of death? Probably 4 X Unknow	'n
re law requ e has been age 2 shou	Completed by	1. DEMENTIA 2. PARKINSON 3. ANEMÍA	DISEASI	E .						psy ormed?	prior t death		
sician: The law certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:					e of Death (Che	1 \(\superset \text{Yes}\)	2x x1		yes 2 No	
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To the within com.		29b. Signature and title of certifier	/			200	icense r	o 194	21	29d. D	ate signed (Mo	nth, Day, Year)	
	ı	30. Name and aderess of person who	completed cause of de	eath (Item	23a) (Type, P	rint)			+ '	-	1		_

State Registrar DHMH 17 Rev 06-2011

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Sadaf Taimur

31. Date filed (Month, Day, Year)

32. Registrar's Signature

46B Thomas Johnson Drive, Frederick, Maryland 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DAWTIN AYE 10 2012 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 4317 Knott Street Beltsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 05-27-1936 Hours Min 213-89-1886 Director 1 🗆 M 2 🗶 F 76 Burma Usual Residence of Decedent 28a-f show 10c. City, Town or Location Examiner must be notified at Director Prince Georges Beltsville 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20705 4317 Knott Street Burma within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . O. 1 Never Married 2 Married þ ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Asian "natural", 3 ¥ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Own Business Vendor or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PAW OHN NANG HLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 permit. Page 1 and 2: Department of Health 4317 Knott Street Beltsville MD. 20705 THIKE BA / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If 10-14-2012 | Glen Burnie, MD. Atlantic Crematory any injury 22. Name and Address of Facility Fleck Funeral Home Signature of Funeral Service Licensee 186-1 7601 Sandy Spring Rd. Laurel, Md. 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes X Natural 5 Pending 2 No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Yes 2 No

pondermilled Suite 600 Glorton 2070

Year

1X□ Yes 2 □ No

8:00 A M

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Joulyne

263748

Koucekhou,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Walter 208 A M 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 577-50-7467 **Director** 1**X X**M 2 □ F 75 Yrs May 8,1937 Washington DC Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Lothian Anne Arundel 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 USA 996 Tequila Strait Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Marines If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify: Specify: White 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Building Engineer Capital Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Lee Allen Nora McHale Department of Health and Important; If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3889 Queen Anne Bridge Rd. Davidsonville, MD 21035 Neal C. Allen/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Crownsville Vet.Cem. Oct.19,2012 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral 6512 NW Crain Hwy. Bowie, MD 21. Signature of Fundry Senice licensee Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ρ in the past 12 months? Dav Pregnant at time of death 9 Unknown 9 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2- No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page certificate 2- No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ၉ 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending n 24 hours after death.

e Funeral Director, Aft
bletely filled in by the ful 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUO 64379 10

State Registrar

DHMH 17 Rev 06-2011

OCT 15 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rhei

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medical Parkney Sute 210 Amapolo MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER8, 2012 Physician/ ASSIE 12:15PM ALBERTA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Director 1 □ M 2 1 F 225-65-4045 48 7/12/1964 Ghana Usual Residence of Dece ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick MD Frederick 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Completed by Funeral 5321 Saint Mawes Court 21703 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: permit. Pege 1 and 2 should be filed within 72 hours eft Department of Health end Mentel Hyglene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Examples. If Yes. Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Nurse-Carroll Comm, Hospital Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Nicholas Assie Beatrice Okai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgina Ofori-Obeng/sister 5321 Saint Mawes Ct., Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) Labadi Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/30/2012 Accra, Ghana 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Physician/ Breast disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Examine Due to (or as a consequence of): ettending physicien end I for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 ☐ Yes 2 ☐ No funerei director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funere 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) allele October 8,2012 D0073197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANA I S. POY M.D. 400 WEST 75 STREET FREDERICK MAY LAND 21701

Registrar
DHMH 17 Rev 06-2011

State

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT. 1 4 Day RICHARD POOLE BROWN 2012 10:35A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK TRANOUILLITY AT FREDERICKTOWNE FREDERICK 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 218-30-4994 1 ⅓ M 2 □ F 88 08/10/1924 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD FREDERICK FREDERICK 1 🗆 Yes 2 🗹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6893 SNOWBERRY COURT 21703 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☑ Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS OWNER FARMING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HATTON DARBY BROWN MARY POOLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6893 SNOWBERRY CT., FREDERICK, MD 21703 IDA LU BROWN / SPOUSE Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State MONOCACY CEMETERY 10/18/2012 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of/Funeral service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ OYGNAN Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Yes 2 □ No a \square Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ➡ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) ၉ ALH 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 1126 OPALCT, HAGERSTOWN, MD 21740 M.KHALID WASEEM, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

12-07776 S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Shawn E. Beals		1- For State Registrar	St	ate of Marylar			nt of Health e <i>of Death</i>	and Men	ıtal Hygier	ne Reg.	. No. 201	2 3539
Physici		1. Decedent's Name				-			2. Date Mor	e of Death	Day Year	3. Time of Death
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		21. Signature of Fur	neral Service	Deune	1		P.O. Box					
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Box 6876(c death certificate the attending phy- ed for use as the b	cian	past 12 months		I TIVE DIL	n it at time of de	2 ∐ eath 5 ⊡	Fetal death Other (Specify)	-	c pregnancy		Month	Day Year
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Cords, law requir has been s	Completed								— [·	autopsy performe	prior to	completion of cause of
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,		(0110011 0111)		hysiclan: To the best of miner:On the basis of and manner state	examination a	-						
H S H S	Medi	29b. Signature and	title of certifie					cense number		2	9d. Date signed (M	onth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 7 Day Physician/ Month OCT. FRANKLIN TURNER BYNAKER, JR. 201^{ea} 11:10P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENESIS HEALTH CARE ROCKVILLE ROCKVILLE MONTGOMERY Birthplace (State or Foreign Country)

__ 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex 8 Date of Birth **Funeral** Days (Month, Day, Year) 09/19/1932 Hours Director 214-28-4938 1 M M 2 - F 80 VA Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD MONTGOMERY ROCKVILLE 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 239 13773 TRAVILAH ROAD 20850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 12 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "naturei", Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) AUTO MECHANIC AUTO REPAIR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file nd Mental H marked of ၉ FRANKLIN TURNER BYNAKER, SR. OLGA MAUDE MARSTON and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: if Item 27 is any injury or other trau KENNETH BYNAKER 13773 TRAVILAH RD., ROCKVILLE, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State STAUFFER CREMATOR \$10/22/2012 FREDERICK, MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): physician Physiclan/Medical DIABETES MELLITUS Box 68760 use es the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Pregnant at time of death Month Dav Year signed by the et Id be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funerel Director: After this certificate has been six completely filled in by the funeral director, page 2 should it. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** æ 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No ٥ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number dut. OCT. 19, 2012 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GANTT MD 191 29 DOCTORS DR GERMANTOWN MD 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:40 P 210-12 Physician/ October Day 5 Elaine Blair Margaret Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 216-30-4591 80 Director 1 □ M 2 🖺 F Sept. 29, 1932 Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland | Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22400 Clarksburg Road 20841 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and 2 should be filed within 72 hours aft Health and Mental Hygiene. em 27 Is marked other than "natural", 3 ☐Widowed 4 ☐ Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 11 Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Goldsworthy Pau1 Edward Theresa Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Toth - Daughter 22300 Clarksburg Road, Boyds, Maryland 20841 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 1 D Burial 2 Cremation 3 Removal from State Clarksburg Methodist 10/20/12 4 Donatteo 5 Other (Specify) Clarksburg, Maryland 21. Signature of Fundral Service Licensee 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home over 26401 Ridge Road, Damascus, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ibrillation 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at s after death. I Director: After t 1 Natural 5 Pending worl 1 ☐ Yes 2 ☐ No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ge and title of certifier 29b. Signat 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702

Registrar
DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Day Evelyn Elizabeth Boyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2741 Flintridge Dr. Myersville Frederick 8. Date of Birth (Month, Day, Year) 6/25/1919 Birthplace (State or Foreign Country)
 P A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2x F Director Yrs 175-05-3749 93 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Myersville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2741 Flintridge Dr. Funeral 21769 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. Is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 department store sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Randall Lebo permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked Edith Nagle 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2741 Flintridge Dr., Myersville, MD 21773 Dianna Berkey (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Smithsburg Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/12/2012 Smithsburg, MD 1. Signature of Fune al Service Lo 22. Name and Address of Facility
Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) physician Physician/Medical Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🔲 Probably Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 After this certificate Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work 5 Pending Division 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check

29b. Signature and title of certifier

CASPEL

31. Date filed (Month, Day, Year,

TRE

illes

30. Name and address of

State Registrar

DHMH 17 Rev 7/2009

Wath

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

BIGHOS

TREBERICE MD 2170

29d. Date signed (Month, Day, Year)

12

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns HOPKINS Baltimore BALTIMORE 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min. (Month, Day, Year, Hours Director <u>216-66-26</u>94 1 - M 2 XF 67 1/8/1945 GERMANY Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEI ODENTON ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be 21113 UNITED STATES 815 LAMOKA DRIVE 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with, and Mental Hygien is marked other th 12 EXECUTIVE PROPERTY MANAGEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or act. FREDERICK BAUHOF MARIA WAGNER other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT ABBOTT/SON 815 LAMOKA DRIVE, ODENTON, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State CHESAPEAKE CREMATION 4 Donation 5 Other (Specify) 10/15/2012 STEVENSVILLE, CENTER 22. Name and Address of FacilityLASTING TRIBUTES HELFENBEIN & NEWNAM CREMATION & 814 BESTGATE ROAD, ANNAPOLIS, MD 21. Signature of Funeral Service License art 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ non-small disease or condition resulting in death) adenocarcinoma ung Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence of sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certiicense number

State Registrar strar's Signature

Baltimore, Hd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 201

Shieh

Eugenie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Medical 4a. Facility Name if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Anne Arundel Arno1d 1232 Jones Station Rd. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** Days Hours (Month, Day, Year) Country) 220-30-0158 Director 1 🗆 M 2 🗗 F 5 1919 Nov Maryland 92 1 and 2 should be filed within 72 hours efter death with the Maryland of Health and Mental Hygiene. Item 27 is merked other then "neture!", or items 23e or 28a-f show other treumatic event, the Medical Evarians must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No **Arnold** lary1and Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 1232 Jones Station Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Family Domestic 6th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ethel Holliday James Minor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, Md. 21012 1232 Jones Station Rd. Elsie Watts(Daughter) 20a. Method of Disposition 20b. Place of Disposition Warne of cemetery, crematory or other 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
important: if ite
eny injury or ott 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10-24-12 Annapolis, Md. Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Miniame Acres cof Scilisons Mortuary, P.A. Signature of Funeral Service Licenses Annapolis, Md. 21401 1922 Forest Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARDI Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consiquence of) Exam ettending physician end for use es the buriel-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death sate has been signed by the cage 2 should be detached a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No ne Hospital or Attename.
In 24 hours after death.
the Funerel Director. After this certificate
the ""filed in by the funeral director. p? certificate Yes 20 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 2 LLH6 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funerei Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CHA

Registrar
DHMH 17 Rev 06-2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForAMEND#19b per FH State of M 1 - State 10/15/2012 AACO HEALIH DEPT Registrar	aryland / I	Department of Certificate of		and Mental Hyg	giene Reg. No.201	2 35403
	Physicia		1. Decedent's Name (First, Middle, Last) Edward Spencer Beck, Sr.				2. Date of Dea Month October	th Day Y	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) 556 Ferry Point Road		4b. City, Town,	or Location nnapo	of Death	4c. County of	
	Funeral Director		078-07-3348 1 ⋅ x м 2 □ F	ge (In yrs. last birt	thday) If Under 1 Yea Months Days		24 Hrs. 8. Date of Birtl (Month, Day 8/11/1	; Year)	Birthplace (State or Foreign Country) New York
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel	10c. City, Town		napo1:		919 [1	10d. Inside City Limits
	vith the Mi 23a or 28 st be noti	eral Dire	10e. Street and Number 556 Ferry Point Road		10f. Zip Code			10g. Citizen of Wha	
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3XXWidowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates.	47-49	If Yes, specify Cul	ban, Mexicar lo Specify.	gin? (Specify Yes or No- n, Puerto Rican, etc.)		American Indian, White, etc. White
Baltimore, Maryland 21215-0036	vithin 72 ho jiene. er than "na the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5)	1191	i. Decedent's Usual Occu (Give kind of work done life. DO NOT use retired Physician	e during mos d)	t of working	16b. Kind of Busin	ness/Industry
/land	should be filed valued be defined valued by is marked other raumatic event,	To Be	17. Father's Name (First, Middle, Last) Lewis M. Beck				er's Name <i>(First, Middle, I</i> Norma A. Nor		
, Man			19a. Informant's Name/Relationship (Type, Print) Edward S. Beck, Jr Son				er or Rural Route Number, Annapolis,		e, Zip Code)
imore	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place o cemete Balti	of Disposition (Name of ery, crematory or other pl more Cremat	ace) Ory	Date 10/11/2012	20c. Location - Cit	*
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee Ryselin T. Wlother	1			John M. Ta Loucester St		eral Home lis, MD 21401
ine.	Physician/ Medical		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) a. Due tor as				cardiac or respiratory arro		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Errier underlying	a consequence	of):				
_	ate be executed physician and the burial-transit	dical Examine	Cause (Disease or injury that initiated events c.	a consequence	of):			110.00	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal death	h 3 Ectopic pregna 5 Other (specify)			23d. Date o	,
s, P.O.	iires that the signed by t Ild be detach	by	Part II. Other significant conditions contributing to death b	out not resulting i	in the underlying cause of	given in Part	2001 210		te to the cause of death?
Records,	ysician: The law require is certificate has been si director, page 2 should	Completed					24a. Was a autop perfor 1 🗌 Yes	sy prio med/? dea	e autopsy findings available r to completion of cause of th?] Yes 2 No
/ital	sician s certifi lirector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input			hor	th (Check only one)	a 🗆 au	
Division of Vital	tending Phys death. :tor: After this / the funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Da) 2 Accident Investigation	ıry 28b. 1	Time of 28c. Injury wo		28d. Describe ho	ow injury occurred	респу)
Division	tal or Attending Is after death. Is al Director: After ed in by the funer	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injudiding, et		arm, street, factory, office	•	28f. Location (Si City or Town		r Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of e	avamination and/a	or investigation in my only	sion donth or	courred at the time date or	d place and due to	the course(s) and manner stated
	To t To t		29b. Signature and title of certifier Marvey of Steinfor	ld 1	29c. Licen	se number	te and place, and due to the	29d. Date signed (NOCT 9	Month, Day, Year) 2012
Ä.	+10+		30. Name and address of person who completed cause of death of the completed cause of death of death of the completed cause of	leath (Item 23a) ((Type, Print) 6	131	SHADY VE MO	51DE	764
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	parks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#9 per FH State of Ma State 10/16/12AACO HEALTH DEPT CMH Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ mari Bandico UCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death **Examiner** County of Death Anne avundel Medical 9. Birthplace (State or Foreign Countrypennsylvania PENNSYANIA 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs: last birthday) If Under 1 Year | Il Under 24 Hrs. **Funeral** Director 216-40-6150 1 □ M 2 🗓 F APRIL 25,1938 74 Usual Residence of Dece or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 X No MARYLAND ARNOLDANNE ARUNDEL 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral UNITED STATES 21012 Examiner must 630 BRETON PLACE items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 LI IS marked other than "natural", traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) HEALTH CARE 12 NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROSALIND SHIELDS JOSEPH BAUDINO permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 BRETON PLACE, ARNOLD, MD 21012 GERALD COOLEY/HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TER CREMATION 10/13/2012 STEVENSVILLE, MD 21. Signature of Funeral S CARE HELFENBEIN & NEWNA 814 BESTGATE ROAD, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause an each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Diratory disease or condition resulting in death) Medical Due to (or 1 a consequence of **Examiner** Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a son sequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Ulmonarc and that initiated events resulting in death) Last Due to (or as a consequence of) physician as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate has funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours area Corrector. After Funeral Director. After Corrected filled in by the fur 1 Natural injury work? 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day State 16 2012

Registrar

		_ For	State of Ma		Black Indeli id / Departme					_egible.	
		State Registrar			Certifica	te of I	Death		Reg. No.	2012	35405
Physicia Medic			e Celia BL	UME				2. Date of De		2012	3. Time of Death 11:30 Å M
Examin	er	4a. Facility Name (if not institution, give		ion			r Location of Death r Spring	1		ounty of Death Montgon	nery
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. l		der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th V Veerl	9. Birthr	place (State or Foreign
Director		578-50-4967 Usual Residence of Decedent	□ M 2 💢 F	105	Yrs.	3 Days	1 TOURS IVIIII.	July 2			insylvania
show dat	tor	10a. State 10b. County		10c. Cit	y, Town or Location	ning	1 1			1	0d. Inside City Limits
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death v items ner mu		11. Marital Status	12. Was Decedent Ev	er in U.S	S. 13. Was Dec	edent of F	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Decify Rican, etc.)	14	. Race - Americ	
after o	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give	10		11	Specify:	7 110411, 0101,	Sp	Black, White, becify: White	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 D	Removal from State	0	Place of Disposition (A cemetery, crematory o	r other pla		Date		ation - City or To	
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Pe E E				010	708 254 C	arro	17 St., N	W, Wash	ingtor	n, DC	20012
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Osit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence of):						
oe executed ician and burlateagsit	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequ	uence of);						
ate be ohysici the bu			d								
pertification of the second of	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o				***		23	d. Date of deliver	erv
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at the ed by tl detach	/ Phy	9 Unknown Part II. Other significant conditions of	ontributing to death bu	t not res	sulting in the underlyin	g cause gi	ven in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
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ig Phy ter this neral d	te: To	27. Manner of Death	28a. Date of injur (Month, Day,	У	ER/Outpatient 3 L 28b. Time of injury	28c. Injur	ry at	ome 5 Resi 28d. Describe I			9
tendir Jeath. tor: Af the fu	Certificate:	1 🛣 Natural 5 🗆 Pending 2 🗀 Accident Investigatio 3 🗆 Suicide 6 🗀 Could not b	n		М	1 🗆	Yes 2 No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 2 should be detached for use as the but be the propriet.		4 Homicide determined			ome, farm, street, fact	ory, office		28f. Location (City or To		Number or Rurai	Route Number,
Hospi 24 hou Funeri stely fill	Medical	(Check 2 Medical Exam		aminatio	n and/or investigation,	in my opini	on, death occurred a	at the time, date a	and place, a	nd due to the ca	use(s) and manner stated
To the within To the To the	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the	best of r		9c. Licens		lace, and due to		and manner as s signed (Month,	
lo		1900	m.D.			D 66	249		0ct	ober 12	2, 2012
		30. Name and address of person who Jonathan Duran, N	completed cause of de	ath (Item	est Glen R	oad,	Silver S	pring, N	1D 20	910	
Stat	е	31. Date filed (Month, Day, Year)									-
Registra		OCT 1 7 2012	12 Dece	A.	Market.						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 1 3 , 201 October Physician/ Robert Blevins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Harford Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** sex 1X M 2 □ F Days Hours 08/10/1922 Virginia 90 Director 285-16-5945 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 133 Wilson Street 21078 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates: 1939 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) 8 <u>Agriculture</u> Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Creecy Howell Lawrence Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Wilson St., Havre de Grace, MD 21078 Bonnie Lee Blevins(wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/17/2012 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham 22. Name and Address of Facility Zellman Funeral Home, P.A. S. Washington St., Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final congestive heart failure Physician/ hours disease or condition Medical resulting in death) Due to as a consequence of) myocardia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) ng physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 ☐ No 9 Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The L 24 hours after death. Funeral Director: After this certificate h 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 2 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Robert Medical 29a. Certifier 📂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the lawithin 2 To the F Cartifying Nurse Practioner Tot! best of any knowledow drieth 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0056296 10-15-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Birnbaum 500 upper Chesapeate Drive Bel Air mo 21014 31. Date filed (Month, Day, Year) State OCT 1 9 2012 Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a)

CT'2"5 20

OCME

and manner stated.

29b. Signature and title of certifier

31. Date filed (Month

Patricia Aronica-Pollak MD.

Assistant Medical Examiner

Registrar's Signature

Bresenk

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 12, 2012

State

Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physici Med Exami

Funera Director

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completely filled in by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. If yes, outc 1 Live B 4 Pregn 9 Unkno	ant at time of	ancy al death 3 _ death 5 _	Ectopic p		,					ite of del	ivery Day Year
ould be deta	þ	Part II. Other signif	icant condition	ns contributing to de	ath but not re	sulting in the u	nderlying o	ause give	en in Part	l.					the cause of death?
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lrector	<u>m</u>	25. Was case referred examiner? 1 \sum Yes 2		Hospital:	/	1		Othe	:	th (Check		_			
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	8	30. Name and addice	ess of person w	tho completed cause	of death (Item	n 23a) (Type, Pi	int) Fe SI	20,	Ba	Himo	re, Mi				
Stat gistra	e ir	31. Date filed (Mont)	h, Day, Year) T 2 6 20	12 Sent	gistrar's Signa		W								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 222, 2012 Physician/ Claudia Joyce Cosgray 8:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oakland 467 West Liberty Street Garrett Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 236-34-5673 Director 1 □ M 2 □XF 90 7/31/1922 West Virginia 28a-f show 10b. County 10c. City, Town or Location 10a. State event, the Madicel Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Oakland MD Garrett 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 467 West Liberty Street 21550 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: If Yes, Give Year or Dates Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene. If item 27 is marked other the or other traumatic event, the Oil Company Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Devine Rush Ada Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6215 Woodwinds Ct., Mt. Airy, MD 21771 Joyce Cosgray/ Daughter 20b. Place of Disposition (Name of County of graphy of ether place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once, 10/23/12 Davidsville, PA Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Newman Funeral Homes, 2nd St., Oakland, MD 21550 203 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examin After this certificate hes been signed by the attending physicien and foreral director, page 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 115 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. Fourth St., Oakland, Thomas Johnson 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 2 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October COOK 12, 2012 9:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6029 Buffalo Rd. Airy Carroll Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 212-38-7446 1 🗆 M 2 🗶 F 74 July 19, 1938 Maryland ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Mt. Airy 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6029 Buffalo Rd. 21771 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Montgomery County College (1-4 or 5+) Cafeteria Manager Schools Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event 2018. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Everett Cecil Friend Miriam Elizabeth Hoye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester L. Cook/Son 80 North St., Proctor, VT 05765 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20cy Meth. Cemetery Oct. 17, 2012 Friendsville, MD 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronald disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year the Hospital or Attending Physician: The law requires thet the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown heart discord Valvuler 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an HTN weight lost To the Hospital or Attending Physiclan: I within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1111 140055/04 10/12/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) OCT 17 DHMH 17 Rev 06-2011

Griffin, 1502 S.

Main St., Suite 202, Mt. Airy, MD

21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Cert	tificate of L	Death	Re	g. No. 20	12	35411		
	Physicia	n/	Decedent's Name (First, Middle, Last)				Date of Death Month		Year	3. Time of Death		
	Medic		Toni Lee Cunningham				october		12 Year	12:15 P M		
	Examin	er	4a. Facility Name (if not institution, give street and number) 7207 Fish Hatchery Road			Location of Death		4c. County	of Death Frede	1		
marrie.	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign		
	Director			3 Yrs.	Months Days	Hours Min.	Month, Day, Dec. 30,	1958	Vir	ginia		
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	ation	1141			1.	10d. Inside City Limits		
	faryla 8a-f s tified	ect	Maryland Frederick		Frederic	k				1 🗆 Yes 2 🔀 No		
	the N	Ξ	Maryland Frederick 10e. Street and Number		10f. Zip Code	K	1	0g. Citizen of	What Cour	ntry?		
	nwith	Funeral Director	7207 Fish Hatchery Road			1701		U	SA			
	r item		11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Ves 2 ☑ No	n U.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Speci n, Mexican, Puerto R	ify Yes or No- ican, etc.)		e - Americ			
Baltımore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland to Mental Hygiene. In Mental Hygiene. An article of the than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give Year or Dates.	1	☐ Yes 2 🌠 No	Specify:		Specify	: 1	White		
2-C	2 hour "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occup	ation during most of working	, 1	16b. Kind of B				
121	thin 73	mo.	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired) Horticol			Agri	.cultı	ure		
א ס	ed wil Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First. Middle. M					
an	l be fil lental rked tic ev	욘	Florenzo Dedonato				ginia Myers					
ar	should be to and Menta		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street a			ber, City or Town, State, Zip Code)				
Σ.	1 and 2 should be of Health and Men item 27 is marke other traumatic		Brian Cunningham / Husband	7207	Fiah Ha	tchery Rd.	, Frede	rick,	MD 21	1701		
ore			1 Burial 2 🔽 Cremation 3 🗆 Removal from State		atory or other plac	e)		20c. Location	•	1		
<u>=</u>	it. Pag irtmen irtant: njury		4 ☐ Donation 5 ☐ Other (Specify)				Maryland					
Ra	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licensee	er Fune Frederi	MD 21702							
		Н	23a. Part 1 Enter the disease, or complications that caused the		Approximate							
P	hysician/		shock, or heart failute. List only one cause on each line. Immediate Cause (Final disease or condition	oral V	as cul	er acc	ident	-		Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a con	sequence of):	* /		- 4 / /		\neg			
	LXaIIIIICI	F	Securifically list nanditions h. Due to (or as a con	rtens	10N							
	ed sit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	sequence of):	use							
	xecut n and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a con						_			
2	ifficate be executed ng physician and as the burial-transit	Medical	d									
09/8	tificat ing ph s as th		IF FEMALE:	323								
Pox 6	ath cert ittendir or use	ian/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of proceeding the past 12 months? 4 Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	:y		1	ite of delive	ery Day Year		
ŭ .	v requires that the death certi been signed by the attendin should be detached for use	Physician/	1 Yes 2 No 9 Unknown	gordean 5 🗆	Ottler (specify)							
Э.	that the ned by the e detach	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.	23e. Did tob	acco use cont	ribute to th	he cause of death?		
	quires en sig suld b	ted t	Tobacco Use				1 🗷 Ye	s 2 No	3 🗌 Prol	bably 4 🗆 Unknown		
S .	law requires nas been sign s 2 should be	Completed					24a. Was an autopsy	/	prior to co	psy findings available impletion of cause of		
å i	sician: The law i certificate has b irector, page 2 s						perform 1 Yes 2		death? 1 Yes	2 🗆 No		
Ita	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	o [] ====	Othe	ace of Death (Check c			10 11			
5	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatient 28b. Time of	28c. Injury		ie 5 🗂 Resider 3d. Describe hov			<i>"</i>		
00	ending sath. ir: Afte	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Yea 2 ☐ Accident Investigation	ar) injury	M 1 🗆	? Yes 2 □ No						
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - / building, etc. (Sp		et, factory, office	28	Bf. Location (Stre City or Town,		er or Rural	Route Number,		
בֿ	spital ours a leral c		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge death or	ccured at the time	date and place and	due to the caus	e(s) and mann	er as state	sd.		
:	To the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examinonly one) 3 Certifying Nurse Practioger: To the best	nation and/or investig	gation, in my opinio	n, death occurred at th	ne time, date and	l place, and du	e to the car	use(s) and manner stated.		
i	Withi To the	_	29b. Signature and title of certifier		29c. License	number		d. Date signe	d (Month, i	Day, Year)		
			> Lilward offer	N	DOO	36610		10-1	1 -	2012		
-	Y		30. Name and address of person who complete cause of death	(Item 23a) (Type, Pr	int)	ChASCON T	o Fre	deric	kn	DO12		
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	l and	V111474 1	/1	70110	- 10			
	Registra		MCT I 7 ZUIZ Penasua	J. B. A	acked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Day 0 2012 Physician/ 5:00 P M Myrtie Belle Cleveland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) June 18, Days Hours Country) 90 214-16-7997 1 M 2 K F 1922 Maryland **Director** 10d. Inside City Limits an "natural", or Items 23a or 28e-f show Medicel Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director Frederick 1 Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8103 Canterbury Drive 21704 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 25 No Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2√ X No Specify: If Yes, Give Specify: 3 ₺ Widowed 4 □ Divorced Year or Dates. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oe filed with... Mental Hygiene. `~d other than "r `≺. <u>the M</u>r Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker 12 should be filed wi alth and Mental Hygie 27 is marked other r traumatic event, t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Elmer Norris Daisy Crist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60103 230 Burnside Circle, Bartlett, Illinois Judith A. Buck - Daughter 1 and 2 s of Health Item 27 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of Important: If It any injury or o cemetery, crematory or other place Parklawn Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ ongesti disease or condition resulting in death) Medical Due to (or as a conjuguence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burlal-trensit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autoosy death? 2 🗆 No 1 🗌 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

C

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	Dharini		1. Decedent's Name (F	irst, Middle, Las	t)							2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		John F	I. Cou	ılter							OC fobe	-7,	2 0 1 2	9:55 A M
	Examin		4a. Facility Name (If no	t institution, give	street and number)			4b. City, To	own, or	Location o	f Death		4c. C	ounty of Death	
					sted Livin					Park				ne Arur	
	Funeral		5. Social Security Numb	- 11	ex 7.Ag ☑M2□F	e (<i>In yrs. l</i> : 87	a <i>st birthd</i> ay Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da)			lace (State or Foreign try)
	Director		212-20-836 Usual Residence of Dec	3 '		<u> </u>				i	1	Nov.29	,1924	Mary	Land
	/land			b. County	_	10c. City	, Town or L	ocation						11	Od. Inside City Limits
	Mar.	tor	MD A	Anne Aru	ındel	5	Severn	a Park							1 □Yes 2 No
	or 28a	Director	10e. Street and Numbe	r				10f. Zip C	Code				10g. Citize	en of What Coun	try?
	th wit	al [342 Prest	confield	l Lane			21	146				Ţ	JSA	
	ems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		5. 13.	Was Decede	nt of His	spanic Orio	gin? (Spe	ecify Yes or No- Rican, etc.)	14	Race - Americ	
20	or it	by Fi	1 Never Married		1 TYes 2 ☐ If Yes, Give	L MMoN	[I	1 □ Yes 2[nite
2-003p	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Extending recognitive must be in filled at		3 Widowed 4 □		Year or Dates:	1	16a Dec	edent's Usual	Occupa	ation			16h Kind	of Business/Ind	luetry
	in 72 n "na leulic	plet	(Specify of	Decedent's Ed	de completed)		(Giv	e kind of work DO NOT use	done di	uring most	of worki	ng	TOD. KING	1 01 1543111633/1110	lustry
7 7	filed within Hygiene. other than '	Completed	Elementary/Seconda	ry (0-12)	College (1-4or 5	o+)	Off	ice Ma	nage	er			Ra	ilroad	
ġ	othe	Be C	17. Father's Name (Firs	st, Middle, Last)		·········			_		r's Name	(First, Middle,	Maiden Si	urname)	
<u>a</u>	Venta Menta Irked Itlc e	To E	Alfred Cou	ulter						Eli	zabe	th Scha	effe	r	
a	2 should be filed wit and Mental Hygien Is marked other th aumatic event, The		19a. Informant's Name		Type. Print)									Town, State, Zip	
≥	and 2 lealth m 27 i		Marie Cou	lter/Sis	ster-in-la									k, MD 2	
ore	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other ODCE.		20a. Method of Disposi		Removal from State	20b. P	lace of Disp emetery, cre	osition (Name ematory or oth	e of er place) maria	1 00	t. 17,		ation - City or To	
Ĕ	Pages ment of l ant: If Ite		4 Donation 5			Du.		ardens		i		2012_1		nium, M	
Saltimor	permit. Depart Import any Inj once.		21. Signature of Furer.	Service Licen	×2		Í	2. Name and	Addres O &	s of Facility Sons	, P.	A. Seve	erna 1	Park Fu	neral Home
_			-	- U	m			195 Rit	chi	e Hwy	,	Seve	erna	Park, MI	21146
			shock, or heart fa	ailure. List only	ofications that caused one cause on each li										Approximate Interval Between Onset and Death
Popular.	Physician		Immediate Cause (Fin disease or condition resulting in death)	aı	a. Enc	St	age 1	arki	~S =	تدامد	Pi	Lease	·		
j	/Medical Examiner		resulting in deading		Due to (or as	a consequ	uence of):								
		e	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin	ions,	b Due to (or as	a consequ	uence of):								
	uted d an s it	Examiner	Cause (Disease or inju	ng iry	,	·	,								
.	exec In and ial-tra	Exa	that initiated events resulting in death) Last	4	Due to (or as	a consequ	uence of):								
09/90	eath certificate be executed attending physician and for use as the burial-transit	cal			d										
õ	rtifica ng ph as th	cian/Medi	IF FEMALE:												
Š O	ath ce ttendi	an/I	23b. Was decedent pro in the past 12 mo		23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pre	egnancy	/			23	3d. Date of delive Month	ery Day Year
2	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eath 5	Other (spe	cify)					MOHIT	Day real
7.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physic	Part II. Other significa	nt conditions of	ontributing to death h	out not resu	ulting in the	underlying car	ise dive	n in Part I	-	23e. Did to	nhacco us	e contribute to t	ne cause of death?
Š,	ires t signe	by	Taren. Other signmea	in conditions of	onthibuting to death t	out not rest	and in the	underlying out	ase give	711111 GTC 1.		1 🗆 \		A.	pably 4 ☐ Unknown
Š	been been should	Completed													
ě	has has	mpl										24a. Was autor		prior to co death?	psy findings available mpletion of cause of
vital Records,	n: Th ficate r, pag		05.146									1 □Yes	2 X No	1 □ Yes	2 □No
5	Attending Physiclan: If death. ector: After this certificity the funeral director, by	Be c	25. Was case referred examiner? 1 ☐ Yes 2 ☐ ¥o		Hospital:	4 0 🗆	5D/0:	0 D DO	Othe	26. Place	of Death	(Check only o	ne)	Assuf	et living
5	Phy er this eral d	<u>1</u> : 1	27. Manner of Death		28a. Date of Inj	ury	28b. Time	of 28	c. Injury Work	_		me 5 Hesi 28d. Describe I		Other (Special	y)
0	nding tth. : Afte e fune	ation	1 X Natural 5 2 ☐ Accident	Pending investigation	(Month, Da	ay, Year)	Injury	м		? Yes 2 🔲 I					
UIVISION	Atter	ifica		Could not be determined	28e. Place of In	jury - At ho	ome, farm, s	treet, factory,	office		_	28f. Location (Street and	Number or Rura	al Route Number,
5	s afte	Certification:	4 DI TOTRICIDE		building, e	ic. (Specii)	y)					City or To	vii, State)		
	To the Hospital or Attending Physician: The I within E4 burs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical	29a. Certifier 15	Certifying Ph	ysician: To the best	of my kno	wledge, de	ath occurred a	t the tin	ne, date ar	nd place,	and due to the	cause(s)	and manner as	stated.
	the hin 24	l edi	one)		and manner s			-				1			
	5 7 § 9	Σ	29b. Signature and title	17	- 1					e number	> ,			signed (Month,	Day, Year)
				١٠٠٠	egi, n	1. D			W >	75	>/		- T	77)
7	1154		30. Name and address	of person who	completed cause of	death (Iten	n 23a) (Type	e, Print)	k	n.,	اسدىدا	(1110 -	~	173	
Ť	Sta	te.	31. Date filed (Month,	Day, Year)	8601 2012 32. Regist	rar's Signa	ture	1.009			16/13	rive	, , ,	0 0	1100
	Registr		n	CT 15 2	2012	wa	A. ,	park							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 | 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2012 Year Physician/ 1000 AM Jacqueline Crumpler October Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Upper Marlboro 10102 Campus Way South Apt. 202 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year, Hours 75 578-50-5455 1 M 2 X X Director June 14,1937 Washington DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County be notified at Director Upper Marlboro MD Prince George's 1 Yes 2XXNo 10f, Zip Code 10g. Citizen of What Country? or 20774 USA 23a by Funeral 10102 Campus Way South Apt. 202 traumatic event, the Medical Examiner must "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4XXDivorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I College (1-4 or 5+) Elementary/Secondary (0-12) 0.P.I.C. Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Grace Fitchett ျှ Sydney Crumpler 1 and 2 should bot Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10350 Globe Dr. Ellicott City,MD 21042 Elizabeth Russell/Executrix 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Page 1 ment of I Department of I Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State OCT. 15, 2012 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 21. Signature / Funera/S/V/ e Licensee ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or comp Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death
Unknown signed by the a 2 **X**No 1 L Yes 2 L 9 L Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by makales Mellitas 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Renel Failore 24a. Was an autopsy performed? Yes 2 X N After this certificate has 2 X No 1 Yes completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 2 🗆 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral C Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conjugation of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 10/15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANHAM MO GABRIE GOOD 32. Registrar's Signature 31. Date filed (Month State OCT 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of N	Maryland / I					lental Hy	giene	110	05115		
			State Registrar	0		Cen	tificate o	Death	1		Reg. No. 🗸) 2			
Pi	hysicia	n/	1. Decedent's Name (First, Middle, Las Wai-Han Ch	,						2. Date of Dea Month October		2012	3. Time of Death 10:30 PM		
~,	Medic Examin		Wai – Han Ch 4a. Facility Name (if not institution, give)	T	4b. City, Town	or Location		october		ty of Death	10.501		
1	-xamm		103 Winnie Place					ersbu				Montgo	omery		
	uneral rector			ex 7. A	nge (In yrs. last birt	thday) Yrs.	If Under 1 Yes Months Day			8. Date of Birt (Month, Day 08/17/	(, Year)	9. Birth Coun Ch1			
land	f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow					<u> </u>		1	0d. Inside City Limits		
e Man	. 28a- notifie	Director	MD Montgo	mery		Ga	aithers						1 X Yes 2 No		
/ith th	23a ol st be	ral	103 Winnie Place				10f. Zip Code 208				10g. Citizen o				
eath w	rems er mu	Funeral	11. Marital Status	12. Was Deceden		13. W	/as Decedent o	f Hispanic O	rigin? (Spe	cify Yes or No-	United	ice - Americ			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ural", or il I Examine	Completed by F	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	X No		Yes, specify Cu			Rican, etc.)		y: Asia			
21215-0036 within 72 hours after giene.	an "nat Medica	omplet	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give k	ent's Usual Occ ind of work dor NOT use retire	e during mo	st of workir	7g	16b. Kind of		dustry		
d with lygien	ther th	Be C		2		Н	omemake					Home			
Maryland 2 should be filed Ith and Mental Hy	arked o	To E	17. Father's Name (First, Middle, Last) Lan Cho Sze						am-Mu:	i Liu	Maiden Surnar	ne)			
, Mar nd 2 shou salth and	n 27 is m er traum		19a. Informant's Name/Relationship (T. Pak—Sun Chu (Spo							Route Number thersbu					
Baltimore, permit. Page 1 and Department of Hea	int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 🛣 4 ☐ Donation 5 ☐ Other (Specia		te cemete	ry, crem	sition (Name of atory or other p			ber 17.	20c. Location	-			
Balti permit. Departn	Importa any inju once,		21. Significantly of Funeral Provide Legislee 22. Name and Address of Facility DeVol Funeral Home, 10 East Dee Gaithersburg, MD 20877												
			23a Part II. Enjer the disease, or com shook, or heart failure. List only of	plications that caus	ed the death. Do r	not enter							Approximate Interval Between		
	icion/ edical		Immediate Cause (Final disease or condition resulting in death)	a. My	ocardial		farctio	n					Onset and Death 1 Hour		
	miner	er	Sequentially list conditions,	b											
cuted	Agi a	kamin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	s a consequence										
60 ate be exec	chysician and the buril transit	dical Examiner	resulting in death) Last	Due to (or a	s a consequence	of):									
6876 Sertificate	ng ph) as th	Med	IF FEMALE:												
Box 68760 death certificate be executed	been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No		n 2 Fetal death at time of death		Ectopic pregna Other (specify)					ate of deliversity	ery Day Year		
P.O. E	d by th	Phys	9 ☐ Unknown Part II. Other significant conditions c			in the ur	derlying cause	given in Par	+1	220 Did to	bassa usa sa	stributo to th	ne cause of death?		
dS, P. quires tha	en signed	ed by	Hypertension	ontributing to death	out not resulting	in the di	idonying cause	giveninia					pably 4 Unknown		
COL	ias bee	Completed	Hyperlipidemia							24a. Was a	SV	prior to co	osy findings available mpletion of cause of		
Be :	s certificate has lirector, page 2 s		Diabetes							1 🗆 Yes	rmed? 2 X No	death?	2 🗆 No		
/ital	s certific director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:			1	Place of De other:							
of V	er this neral d	te: To	27. Manner of Death	1 □ Inpa 28a. Date of in (Month, D		utpatient Time of injury	28c. In	jury at		me 5 🔀 Resid 28d. Describe h)		
on endin eath.	or: After th the funeral	ficat	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	1	ay, rear)	mjury		ork?	□No						
Division of Vital Records, tal or Attending Physician: The law requires safter death.	eral Direct filled in by	l Certificate:	4 Homicide determined	28e. Place of I	njury - At home, fa etc. <i>(Specify)</i>	irm, stre	et, factory, offic	e		28f. Location (S City or Tow		ber or Rural	Route Number,		
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death.	To the Funera	Medical	29a. Certifier (Check (Check only one) 1 Certifying Phy 2 Medical Exam	iner: On the basis of	examination and/o	or investi	gation, in my op	inion, death	occurred at	the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.		
To the within	3		29b. Signature and title of certifier	1 - A : la -	7			nse number 1839			29d. Date sign				
			30. Name and address of person who christopher Dunfo	completed cause of	death (Item 23a) ((Type, Pr	tgomery	Aven	ue, R	ockvill	e, MD	20850			
R	Stat legistra		31. Date filed (Month, Day, Year) OCT 17 2012		trar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Angela Tse Chuang Chu State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 1 2 3 5 4 6 Reg. No. 2 0 1 2 3 5 4										
			- Negistiai	er till cate or beating			3. Time of Death			
	Physicia		Angela Tse Chuang Chu		Month Octob	er II, 2				
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County				
	LAdillill	CI	Suburban Hospital	Bethesda		Mor	ntgomery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under Months Days Hours			Birthplace (State or Foreign Country)			
	Director		176-34-5110 1 □ M 2 ဩ F 80 _{Yrs}			1, 1932	China			
	how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	1 -		10d. Inside City Limits			
	laryla 3a-f s ified	Director	MD Montgomery Pot	omac			1 🗌 Yes 2 🛣 No			
	the M or 28 e not		10e. Street and Number	10f. Zip Code		10g. Citizen of	What Country?			
	with s 23a ust b	Funeral	9927 Logan Drive	20854			USA			
920	o filed within 72 hours after death with the Maryland they giene. A thy giene. A death of the than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Of If Yes, specify Cuban, Mexicant 1 Yes 2 No Specify 	an, Puerto Rican, etc.)	Ple	ce - American Indian, ick, White, etc. Asian			
5-0	2 hour	bet	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during mo	ost of working	16b. Kind of E	Business/Industry			
121	hin 72 ne. than '	Completed	Flementary/Secondary (0-12) College (1-4 or 5+)	. DO NOT use retired) uclear Enginee		Federa	al Government			
_	ed wit Hygie other	ادہ ا	17. Father's Name (First, Middle, Last)		ther's Name (First, Middle					
an	be filed ental Hyg rked oth ic event,	힏	Chung Tsun Hsu		Mann Bin Wu					
Maryland 21215-0036	of and 2 should be file of Health and Mental H fitem 27 is marked of rother traumatic ever	20	19a. Informant's Name/Relationship (Type, Print) 19b. M Charles C. Chu/Son 28	ailing Address (Street and Numb Highfield Aven	ber or Rural Route Numb nue, Port Wa	er, City or Town, shington	State, Zip Code) n , NY 11050			
ē,	1 and of Hea item			sposition (Name of crematory or other place)	Date	20c. Location	- City or Town, State			
<u>m</u>	Page nent c ant: If ury or		141 Burial 2 Greination 3 Nethoval non-State	Heaven Cemeter	y 2012 ²² ,	Silver	Spring, MD			
Baltimore,	permit. Page 1 and Department of Hed Important: If item any injury or othe once.	9	21. Signature of Funeral Service Licensee	Tins Funera Blvd. W.,	1 Home : Silver :	Inc. Spring, MD 20901				
			23a. Part 1. Exter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	as cardiac or respiratory a	rrest,	Approximate Interval Between				
J	h, i ian/		Immediate Cause (Final disease or condition Set Sis				Onset and Death			
Target .	Medical Examiner		Due to (or as a consequence of):							
		ě	Sequentially list conditions, of any feeting to immediate	nia						
	Usi e	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	xecut a and	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
09	ite be executed hysician and the burial-transit	dical	d							
6876	ficate ig phy as th	Med	IE ECMALE.							
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and cappetely filled in by the funeral director, page 2 should be detached for use as the buria-transit	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			oate of delivery Nonth Day Year			
P.O.	that the	y P	Part II. Other significant conditions contributing to death but not resulting in t			tobacco use cor	ntribute to the cause of death?			
) <u>s</u>	requires the been signer should be a	edk	Chronic Respiratory Failure Status	Post Tracheoto	omy 1	Yes 2 No	3 ☐ Probably 4 ☑ Unknown			
of Vital Record	tw requires the street to the	Completed by			24a. Wa	opsy	. Were autopsy findings available prior to completion of cause of			
Rec	nysician: The law his certificate has b I director, page 2 s	S				formed? 2 X No	death? 1 □ Yes 2 □ No			
E	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of De	eath (Check only one)					
Ž	Physic this c	은	1 ☐ Yes 2 ☐ No	atient 3 DOA 4	Nursing Home 5 Res	how injury occu				
n o	ding P th. After t funera	ate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) inju		l l	flow injury occu	neu			
Division	or Attend fter death irector: / n by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location	(Street and Num own, State)	ber or Rural Route Number,			
D	To the Hospital or within 24 hours after To the Funeral Director opposite the Funeral Funeral Director opposite the Funeral Fu	Medical C	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, de (Check 2 M ical Examiner: On the basis of examination and/or in	vestigation in my opinion death	occurred at the time, date	and place, and d	tue to the cause(s) and manner stated.			
	o the	ž	only one 3 Certifying Nurse Fractitioner To the best of my howle	29c. License number			ned (Month, Day, Year)			
0	F 8 F 30		· / -u	D69148		Octo	ober 12, 2012			
				l Georgetown Ro	oad, Betheso	la, MD 2	0814			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 17 2012 32. Registrar's Signature	aki.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 354 Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Elizabeth October 19, 2012 Carson 10:18A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11368 Cherry Hill Road, #204 Prince George's Beltsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 084-16-2421 Canada Director 1 □ M 2 🔀 F 89 13 27 Is merked other then "neturel", or Itams 23e or 28e-f show treumetic evant, the Modical Examiner in unit to notified at 10b. County 10c. City, Town or Location 72 hours eftar death with the Maryland 10d. Inside City Limits Director Beltsville Maryland Prince George's 1 Yes 2 No 10f. Zip Code 20705 10g. Citizen of What Country? United States 11368 Cherry Hill Road, #204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) and Mentel Hyglena. Elementary/Secondary (0-12) College (1-4 or 5+) Management Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ David M. Wellard (unk) permit. Pega 1 and 2 should ba Department of Heelth and Ment Importent: If itam 27 is merket any injury or other trainment 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11368 Cherry Hill Road,#204 Beltsville, Maryland20705 Bonnie Johnson -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 10/20/2012 20c. Location - City or Town, State 1 Bunal 2 XCremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bornald Vores Borg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death cartificete be executed 44 hours after death.

Funeral birector: After this certificate hes been signed by the ettending physician and attain in by the funeral director, page 2 should be deteched for use as the build-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 📈 No
9 ☐ Unknown Month Day a I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined e Funsrei Di Funsrei Di oletaly filled ir Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number October 19, 2012 R057293 30. Name and address of person who coinpleted cause of death (Item 23a) (Type, Print) largo 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Zelmadeen Katherine Davis РM October 2012 9:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Director 230-36-9187 1 M 2 X F 79 Jan. 26, 1933 Virginia Usual Residence of Deced tal Hygiene. 3d other then "netural", or Items 23a or 28e-f show event, the Wedical Examiner must be notified at 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 to Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 90 Waverly Drive, Apt. Q 101 21702 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file Ith and Mental H 27 is merked of treumetic eve Carl Welch Beulah Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) end 2 s Health g Amber Davis / Daughter 24904 Woodfield School Rd. Gaithersburg, MD 20882 20b. Place of Disposition (Name of cometery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 e October 5, ò 1 X Burial 2 Cremation 3 Removal from State Importent: I eny Injury o 2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Memorial Gardens 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): HYVERT ENGIONI. Examiner ULKONAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami for use as the burial-trensi The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month ed by the a detached f been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autoosy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No To the Hospitel or Attending Physicien: i within 24 hours after death. To the Funerel Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after deeth.

nerel Director: After this filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat title of certifier D0062223 PREDE NECK Mg 21702

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

<u>P</u>

Records,

Division of Vital

Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAME OF BOLANT, 176 TIPLEUE,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jeffrey Edward Downs 2012 4:48P October Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min (Month, Day, Year) Hours 215-86-7606 Director 1 🔀 M 2 🗆 F 41 April 28 1971 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland notified at Director Frederick Union Bridge 1 Yes 2 No Carroll MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r 21791 12362 Liberty East Terrace United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 0 þ 1 X Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Heating and Air Technician 12 of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patricia Logan Downs Edward Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Patricia L. Downs / Mother 21101 Camomile Court, Germantown, MD 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State cemetery, crematory or other place, Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 10/19/12 Metropolitan Crem. Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Funeral Home 20882 Darbe Anthony P.O. Box 5038 Laytonsville, trances 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Terminal Throat/Neck Cancer Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir <u> Airway Obstruction</u> The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Asystole P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year been signed by the a should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After 1 X Natural 5 Pending Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) welle 66 227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B 20528 Boland Farm Road, Suite 104, Germantown, MD 20876 M.D. Rita Sharma, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #23a per MD FCHD TM 10/17/12
State of Maryland / Department of Health and Mental Hygiene 2 () | 2

35420

		-	For State Of State Of Registrar	Cer	tificate of D			Reg. No.	, _ 00	, 6
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	Physicia Medic	al	MABEL K. EATON				October		2012 11:24	РМ
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	yland -f shc ed at	cto	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City	
	e Mai r 28a notifi	Director	MD Frederick 10e. Street and Number	Frederic	10f. Zip Code			10g. Citizen of		0N LALS
	/ith th		8533 Indian Springs Rd.		21702			USA	What Country :	
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decede	nt Ever in U.S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-		ce - American Indian,	
ထ္ထ	fter de , or it amine	by	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	XX No	f Yes, specify Cubar ☐ Yes 2 😿 No		Rican, etc.)		ck, White, etc.	
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Maryland 21215-0036	and 2 should be fil Health and Mental em 27 is marked o ther traumatic ev		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a					
(b)	and 2 Health Sm 27 Ther to		Peg Bruckart/daughter 20a, Method of Disposition		Indian S					
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. By injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		Cremator			Frederi	Homes, P.A.	
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× 68	death certific ne attending ped for use as	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outco	rth 2 🗌 Fetal death 3 🛚		у			ate of delivery onth Day Y	/ear
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10	ing Pl		27. Man r of Death 1 Natural 5 Pending 28a. Date of (Month)	injury 28b. Time of injury	work	?	28d. Describe	how injury occur	red	
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Division of Vital Records,	l or Attene after deat Director: d in by the	Cer		f Injury - At home, farm, str , etc. (Spec <i>ify</i>)	eet, factory, office		City or Tov		oer or Rural Route Numb	er,
	To the Hospital or Attending Physician. The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physician: To the bes							
	he Ho lin 24 he Fu ipletel	Med	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:							nner stated.
	North Con		29b. Signature and title of certifier		29c. License	number	(29d. Date signe	BER II 2	612
			1441	of death (https://oriotal.org	Datinst)	-601	0		1	.012
	b		30 Name and address of reson who completed cause 7115	Gril For D	DR	FREDER	CICK	MD :	21704	
			31. Date filed (Month, Day, Year) 32. Rev	istrar's Signature	- 1 -					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 1801 P .2012 October Edmond Н. Elburn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Air 1801 Bel 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 219-14-3452 **1** M 2 □ F Director May 15,1924 88 Maryland 001 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a. State with the Maryland Director notified 1 Yes 2 X No Harford Havre de Grace MD 10g. Citizen of What Country? 10e. Street and Numbe ō ian "natural", or items 23a or Medical Examiner must be i Funeral U.S.A. 21078 2205 Titan Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces' Black, White, etc. by 1 Never Married 2 Married 1 X Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Edmond Elementary/Secondary (0-12) College (1-4 or 5+) the Painter Service 12 injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Coleman George Franklin Elburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra 26 Schoolhouse Ln., North East, MD 21901 Edmond H. Elburn, Jr. (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Mem.Gdns. 10/18/2012 Aberdeen, MD 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St., Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesenteric Physician/ Ischemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and I-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 1800413877 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Ushknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page 2 certificate has perforn death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 Inpatient 2 ER/Outpatient 3 DOA မ After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: I or Attending F after death. iniury Natural 5 Pending Accident Investigation 6 Could not be Director: □ Accider
 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 101 121 s of person who completed cause of death (Item 23a) (Type, Print) Loper Chesadeake Shakoor MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 7 Yes 2 No If Yes, Give 1972-		☐ Yes 2 🗓 No		, , , , , ,		ck, White, et /: Whit	
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Maryland 21215-0036	e 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show of ther traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Paul Fisher / son	19b. Mailin	g Address (Street ar	nd Number or	Rural Route Number	er, City or Town, S	State, Zip Co	ode)
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Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 Burial 2 Cremation 3 Removal from State	emetery, cren	sition (Name of natory or other place,		Date	20c. Location	*	
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DIVISION	er der er der ector by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, stre	et, factory, office		28f. Location (S	Street and Numbe	er or Rural R	oute Number,
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	To the hospital of Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check 2 Medical Examiner: On the basis of examination	and/or investi	gation, in my opinion.	. death occurre	ed at the time date a	and place and due	e to the causi	e(s) and manner stated
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			30. Name and address of person who completed cause of death (Item	23a) (Time B	int)					
	/x'		Stephenie Comer-Congred	14 140	14 Mars	h Pil	(e Har	cistum	MO	21742
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ure	1 1)			
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. ? 1. Decedent's Name (First Middle Last) 2 Date of Death Physician/ Month Year Elwood 0152 AM alcolm October 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hester town Hospital Center en 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months **Director** 1 **X** M 2 □ F 215-38-1604 74 10/09/1938 MARYLAND Usual Residence of Decedent 28a-f show 10a. State the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 1 XYes 2 No **OUEEN ANNE'S** MD SUDLERSVILLE 10e. Street and Numbe ō 10f. Zip Code 10q. Citizen of What Country? must be r Funeral 104 MILLER STREET 21661 UNITED STATES Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates. ARMY 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other the r traumatic event, the 12 PLUMBER PLUMBING Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM HENRY FAUST, SR. GRACE HOLDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 SUDLERSVILLE ROAD SUDLERSVILLE, MD 21668 Department of Health Important: If item 27 any injury or other to ROBIN KINCAID / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 10/11/2012 SUDLERSVILLE, MARYLAND 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 370 W. CYPRESS STREET MILLINGTON, MARYLAND 21651 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer. disease or condition hung Medical resulting in death) Due to (or a /a) onsequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine Quality for as a consequence of and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Husi'm. 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Prieumonia 24a. Was an Hospital or Attending Physician; The 24 hours after death. performed this certificate ! 1 Yes 2 No Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the l within 2 To the l

State Registrar 29b. Signature and title of certifier

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Adede

Lanne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karunw

Chester

MO

32. Registrar's Signature

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sep. 45

168782

River Hospital Center

29d. Date signed (Month, Day, Year)

10, 10. 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2012 6:25 A JUDITH EILEEN ANTHONY GOODMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner KENT** CHESTERTOWN CHESTER RIVER MANOR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** 1 🗆 M 2 🗶 F Months Hours 05/08/1951 PENNSYLVANIA 61^{Yrs} Director 189-42-2738 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am pinjury or other traumatic event, the Medical Examiner must be nortified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No CHESTERTOWN **KENT** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 UNITED STATES 102 CRESTVIEW COURT 2. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed WHITE Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** 12 4 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ RAPHAEL E. ANTHONY EVELYN BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 CRESTVIEW COURT CHESTERTOWN, MARYLAND 21620 JEFF GOODMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/11/2012 Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND Kicks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC COLORECTAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No 2 200 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of I Director: After to ad in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Investigation Accident Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direct completed filled in by City or Town, State) Medical

State Registrar

29a. Certifier

(Check only one 29b. Signature and title of certific

31. Date filed (Month

Name and address of person who

32. Registrar's Signature

A SPACE.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

use of death (Item 23a) (Type, Print)

NOP / ROOD Chestortown, MD

PARL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 75 FOR 101/00 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min Director 495-34-5520 1 XM 2 F Yrs Usual Residence of Decede 78 12/24/1933 MISSOURI or than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28e-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND KENT 1 Yes 2 No CHESTERTOWN 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funera 211 DEVON DRIVE 21620 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 2 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify Completed 3 Widowed 4 Divorced Year or Dates 1954-62 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PROJECT CONSTRUCTION SUPERINTENDANT CONSTRUCTION Be other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CARL GREENLEE WILLIE MAY HILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM GREENLEE / WIFE 211 DEVON DRIVE CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of P
Important: If ite
eny injury or ot
once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/02/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Buil feations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e-cause on each line. 23a. Part 1. Enter the disease Part 1. Enter the disease, or complete shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Cauch hung disease or condition Medical resulting in death) Due to (or as a consumence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown After this certificate has been signed by 'funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury death. To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the f 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. Medical 1 Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) boun Bother 9-29-2012 D0059487 12+ 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 200 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 11:35A October John William Grimes 4, 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 215-20-2763 1 🛛 M 2 🗆 F Director 86 Aug. 10, 1926 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28a-f ehow emportant: If item 27 is marked other then "naturel", or iteme 23e or 28a-f ehow injury or other treumetic event, the Madical Evaniner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🏻 No Maryland Montgomery Boyds 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 22510 Slidell Road 20841 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give Year or Dates. WWII 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Sheet Metal 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Walter Estelle Grimes Claudia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19971 19a. Informant's Name/Relationship (Type, Print) 3 Alexander Court, Rehoboth Beach, Delaware Theresa Ann Derville - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) Resthaven Memorial Gardn. 10/19/12 Frederick, Maryland Signature of Funeral Service Licenses 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Part 1. The rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ meumonia lougs disease or condition Medical resulting in death) Due o (or as a consequence of): Examiner obstructive + ears Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director, After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burian-trans. Due to (or as a consequence of) resulting in death) Last Physician/Medical John IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🖾 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ YNo မှ 1 Da Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 M Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OSOLA Ball MD October 15, 2012 5 3317 1x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg Ball, MD Frederick Joseph/ 14220 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of De 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day 5 2012 Physician/ 5:30 A_M Fern Christene Godbee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex 8. Date of Birth Hours Days Min. (Month, Day, Year) 216-22-7965 83 Director 1 🗌 M 2 🔀 F December 8, 1928 Maryland Usual Residence of Deceder or then "neturel", or items 23e or 28a-f show the Medical Evaminer must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Frederick 1 Yes 2 K No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States of America 5595 Teakwood Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 72 hours efter White 1 Yes 2 X No Specify. 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filad within 72 is end Mantel Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Pege 1 and 2 should be filad w Department of Heelth end Mantel Hygi Importent: if Item 27 is merked other eny injury or other treumetic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Rebecca Cutsail Charles Edgar Whipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Kings Court, Wilmington, NC 28411 Richard Godbee / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 19. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of unemploance License 22. Name and Address of Facility **Keeney & Bastord P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ mach ease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as consequence of): Hospitel or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events burlel-tren and Due to (or as a consequence of): resulting in death) Last attending physicien I for use as the burle Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes No ed by the a 9 Unknown 9 Unknown P.O. signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown bean signation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s After this certificete hes autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

ND Yes 2 □ No director, **Division of Vital** æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours efter deeth.

To the Funerei Director: After this completely filled in by the funaral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 🗆 Yes 2 🗆 No Natural Natural injury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) عر 30. Name and address of person willo completed cause of death (Item 23a) (Type, Print) 400 W. 7th Street 3

State Registrar

ALHONAS

31. Date filed (Month, Day, Year)

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LAPAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35428 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Gladys Marie 2. Date of Death 3 Time of Death Green Month Physician/ 10 2012 8:30amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7318 Summerwind Circle Prince Georges Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year, 214-03-6446 94 Director 1 🗆 M 2 🕮 7 14 1918 Maryland Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 X Yes 2 □ No Maryland Prince Georges Laurel 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 20707 - 53087318 Summerwind Circle USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) C & P Telephone Co. Office Manager permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other transcribed. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William L. Williams Catherine E. Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra G. Walbridge Daughter 1303 Homewood Ln. Annapolis, Md. 21401 - 1403Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date st. Mary of The Mills 10/11/2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Cometer Y and Address of Facility Fleck Funeral Home 21. Signature of Funeral Service MA M00544 7601 Sandy Spring Rd. Laurel, Md. 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final GORTIC SteNOSIS Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical certificate be Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title

0/20

Registrar

DHMH 17 Rev 06-2011

State

- Shady Grove Road, ROCKVILLE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15235 Registrar's Signatur

regory H.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ Month Sally Jo Groves <u>October</u> 10, 8:08 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie Health Center Bowie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 270-32-8445 Director 1 M 2 X F 76 Ohio Feb 2, 1936 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland Examiner must be notified at Director 1 X Yes 2 No Maryland Prince George's Bowie ō 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20715 U. S. A. 12033 Twin Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced and Mental Hygiene.

is marked other than "naturaumatic event, the Medical" Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Boat Dealership <u>Business Owner</u> Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emerson Turner Daisy Gertrude Fraley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Groves/Husband Edward 12033 Twin Cedar Lane, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State Department of Important: If any injury or injury or 10/13/2012 | Waldorf, Maryland **Huntt Crematory** 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinsonism Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an page 2 autopsy performed? Yes 2 X No 1 🗌 Yes 2 🗌 No funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 🛣 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23

istrar's Signature

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29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Bay 2012 1220 William Gerald Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, ec 15 578-16-3354 Director Ğeorgia 1 X M 2 □ F 1918 93 Dec Usual Residence of Decedent or then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Tes 2 No Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 620 Severn Ave within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give **Black** 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lighthouse I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Apostolic Church 12th 1yr Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed by Health and Mental Hitem 27 is marked of ပ္ Bitha Willcox Percy Gerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Gerald(Son) 620 Severn Ave Annapolis, Md. 21403 Baltimore, 20a. Method of Disposition 20b.**Alphace of Disposition (Mame of** cemetery, crematory or other place) Memorial Gardens Date 20c. Location - City or Town, State permit. Page 1 a Department of H Importent: If ite eny injury or ot 1 X Burial 2 Cremation 3 Removal from State 10-17-12 Annapolis, Md. 4 Donation 5 Other (Specify) Miname area consecutive of resciling ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Day to for as a consequence off sician and burial-transit Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events HF Precebo Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been signated by the property of the property Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has the completely filled in by the funeral director, page 2 s autonsy performed Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ျှ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner_of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 0CT 12 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Laureral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Me		Certifying	Nurse Practioner:				time, date			ne cause	(s) and ma	nner as s		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALBERT 17:36 PM SEPTEMBER 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 198-26-4936 1 **X**M 2 □ F **Director** Yrs. PENNSYLVANIA Usual Residence of Deceder 77 01/25/1935 show 10a. State 10b, County 10d. Inside City Limits at 10c, City, Town or Location Director notified 28a-f 1 Yes 2X No MARYLAND KENT CHESTERTOWN 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? must be r Funeral 21249 MAINE AVENUE 21661 UNITED STATES an "natural", or items Medical Examiner mu death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working the and Mental Hygiene.
It is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RAILROAD FOREMAN E.T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ HARRIET D. TOAL ALBERT HART, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tran WILMA HART / WIFE 21249 MAINE AVENUE ROCK HALL, MARYLAND 21661 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. JOHN'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2012 ROCK HALL, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND Kuf 23a. Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CHRONIC Phylician/ OBSTRUCTIVE PULM ONAKY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Exami burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s autopsy performe 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၀ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? (Month, Day, Year) injury 5 Pending Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical

5

29a. Certifier

29b. Signature

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and title of certif

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27

State Registrar

DHMH 17 Rev 06-2011

🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD 51301

29c. License number

South Greene St. Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 13, VIOLET MAE COLEMAN HARRIS 2012 6:22 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death TALBOT **EASTON** CANDLE LIGHT COVE 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours **Director** 218-16-8329 1 🗆 M 2 🗶 F 88 Yrs OCT. 15,1923 MARYLAND Usual Residence of Decedent 28a-f show 10a, State 10b. Count the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified QUEEN ANNE'S CHESTER MD 1 Yes 2 X No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 516 DOMINION ROAD 21619 USA items ; permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 'natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 □ Divorced Completed Specify WHITE other than "natu vent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SEAFOOD SECRETARY/TREASURER -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked 2 SARAH REBECCA BROWN ELLISON COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, t: If item 27 is 2308 BLOMMINGDALE ROAD, CENTREVILLE, MD 21617 KAREN OERTEL/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OCT.17, Department Important: If any injury or once. STEVENSVILLE CEMETERY STEVENSVILLE, MD 2012 21. Sign July of Funeral Service FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a cor b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last burial physician Physician/Medical Records, P.O. Box 68760 the as ed by the attending of IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 1 Yes 2 Unknown Unknown signed by t d be detach Part II. Other signifu ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tor; After this certificate has been sightly the funeral director, page 2 should I 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hydlocophtl perforn Norma 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica Be examiner' 6 X Other Specific Other: 4 Nursing Home 5 Residence 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month

Registrar

State

31. Date filed (Month, Day, Year)

OCT 15

10

Carsevall

Name and address of person who completed cause of death (Item 23a) (Type, Print)

202

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dianne Michele Harding October 10, 2012 ear 9:40 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year 220-88-7671 Maryland Director 1 □ M 2 🕱 F 48 July 29, 1964 Usual Residence of Decedent or items 23a or 28a-f show the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Union Bridge 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21791 United States 10633 Green Valley Road death \ Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin one. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barbara Stump John F. Molcan 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $10633~{
m Green}~{
m Valley}~{
m Rd.,}~{
m Union}~{
m Bridge,}~{
m MD}~21791$ Thomas E. Harding, Sr. / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 15, Restrace of Disposition (Name of Restrace)
Restrace Agent Gardens 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Frederick, Maryland 21. Signature of Funer Service Licensee Resthaven Fufferal Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Pa Priter th shoot, or hear e risease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Immediate Caus, Final disease or condition resulting in death) Onset and Death years Physician/ Breast Cancer Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last as the burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☒ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 X No death?

1 Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No ER/Outpatient 3 DOA 1 X Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of after death. Director: After 28d. Describe how injury occurred 1 🔁 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) UP D 68104 October 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 516 Trail Avenue, Frederick, MD 21701 Eric Bush, M.D. 31. Date filed (Month. 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1:15 P M 10 2012 Arthur Carlton Huffer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tranquillity of Fredericktowne Frederick Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 1X□ M 2 □ F 90 Director 220-16-3891 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Frederick Middletown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21769 2532 Sumantown Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the M-dical Examin þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 G:Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) lumber co. salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rodney J. Huffer Alma Poffinberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carroll Huffer (Brother) 5421 Broad Run Rd., Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation Removal from State Lutheran Cemetery 10/17/2012 Middletown, MD 4 Donation 5 Gther (Spec 22. Name and Address of Facility Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 21. Signature of Furler ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate art 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final Interval Between Onset and Death 60 Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine (0 attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death ☐ Pregnam. ☐ Unknown signed by the a d be detached for 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 🗆 Yes 2 🗆 No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence \(\frac{\lfloor}{4}\) Other (Specify) ALH 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٥ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending iniury work?
1 Yes 1 Natural 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-16-2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

N MY HAWLED WASEM ITE OPAL CI AAGERSTIN ILLA 3 Day, Year) 32. Registrar's Signature, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35436 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ames Month 330 P M 201 Medical 10 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Director 446-38-0017 1 XM 2 □ F 72 11/18/1939 OKLAHOMA 10b. County 10a State in than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 903 RIVER FALLS COURT 21401 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1963 1 ☐ Yes 2 🖾 No Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ NAVAL OFFICER, CAPTAIN DEFENSE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည of Health and Menta fitem 27 Is marked r other traumatic ev LOWELL HOWARD RUTH WILLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN HOWARD/WIFE 903 RIVER FALLS COURT, ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State CHEŚAPEAKE CKEMATION 10/16/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS Signature of Euneral Service READ ANAPOLIS MD FUNERAL CARE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition MOAT Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Conjury that initiated events Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificete be Box 68760 as the l IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day ned by the at detached for Pregnant at time of death 5 Other (specify) Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, cate has been sig Completed 1 🗌 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniurv 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sut 210 2003 Med

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year) 0CT 16 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08 30 12 Year MOCEPO reeno 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Ye Country)
Maryland 212-78-6839 Hours Director 1954 1 M 2X F 53 Sept Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Bent: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Arnold 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 891 Wilson Rd. 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes Give 3 Widowed 4 Divorced Specify: **Black** Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Blind Institution College (1-4 or 5+) Elementary/Secondary (0-12) 12th Cook State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Henson George Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Hicks (Husband) 891 Wilson Rd. Arnold, Md. 21012 Baltimore, 20a. Method of Disposition 20bt Place of Disposition (Name of 1 -20c. Location - City or Town, State Date permit. Page 1
Department of I
Importent: If it
eny injury or or 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U.M. Church 10-13-12 Edgewater, Md. Winsame Rosaces of EaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician ance Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician ched for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ racheoton 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy Yes 2 No After this certificate 1 Ves 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 0CT 12 2012

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 14 Physician/ 2012 gear 9:50 A HIRSCHFELD Josef Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 22 Tivoli Lake Court Silver Spring If Under 1 Year | If Under 24 Hrs Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** (Month, Day, Year) 218-66-6185 **Director** 93 Romania Feb. 24, 1919 Usual Residence of Decedent or 28a-f shov notified at show 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 🗆 Yes 2 🖔 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 20906 United States 22 Tivoli Lake Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 🔀 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Jewelrv Jeweler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fanny Rudolph Hirschfeld (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

C+ Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type, Print) 22 Tivoli Lake Ct., Silver Spring, MD Judy Cohen, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Judean Memorial Gardens 10/15/12 Olney, MD 4 Donation 5 er (Specify) Torchinsky Hebrew Funeral Home St., NW, Washington, 20012 23a. Part (Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ iongestive Heart Failure disease or condition Medical resulting in death) Due to as a consequence of) Examiner condition of the conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant

been signed by the should be detached this certificate has page 2 funeral director,

attending physician and I for use as the burial-trans within 24 hours after death.

To the Funeral Director: After filled in by the

þ

Completed

Be

Medical Certificate: To

				1 \(\text{Yes} \) 2 \(\text{L} \)	□ No 3 □ Probably 4 ☑ Unknown									
				24a. Was an autopsy performed? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No									
25. Was case referred to medical		26. Place of Death (Check only one)												
examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1													
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28b. Time of 28 injury M	3c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred									
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	1 28a Place of Injuny - At	home, farm, street, factory, ify)	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier 1 Certifying P	nysician: To the best of my kno	wledge, death occurred at	the time, date and place,	and due to the cause(s) an	d manner as stated.									

3 Ectopic pregnancy

5 Other (specify)

Pregnant at time of death

g Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R087926 10:15:12

address of person who completed cause of death (Item 23a) (Type, Print) N. P., 15825

Shady Grove Rd. #140 Rockville, MD 20850

Day

Month

23e. Did tobacco use contribute to the cause of death?

State Registrar

completely

in the past 12 months?
1 ☐ Yes 2 ☐ No

Hospital

12-07616 Ch

Please Type or Print in Rlack Indelible Ink Figure All Copies Are Legible

narles Hall		St	tate of Maryland	/ Depa	artment of H	lealth an				_	201	2 3543		
Physiciar	.7	1-For State Registra AMFND#20b, coet 1. Decedent's Name (First, Midd	<u>rFH, 10/17/12BM</u>	Mode	rtificate of D	eath		12.	Re Date of Dea	eg. No.	2011	3. Time of Death		
edical Examin		Charles Edward	d Hall					(Month October 8	Day , 2012	Үеаг	0822 hrs		
		4a. Facility Name (if not institution 8118 Good Luck Road				City, Town, or anham	Location of E	Death	eath 4c. County of Death Prince George's					
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. I	-	f Under 1 Yea			B. Date of Bir	th (MM/DD/	YYYY) 9. Bir	thplace (State or		
Director		189-22-5288	1 X M 2 F	82	Yrs.	Months Day	rs Hours	Min.	12/03	/1929	Co	untry) PA		
Au A	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location							10d. Inside City Limits		
* .	ğ		e Georges	Sea	abrook							1 X Yes 2 No		
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If if item 27 is marked other than "natural", or items 23a or 28a-f show unter fraumatic event, the Medical Examiner must be notified at once.	runeral Director	10e. Street and Number				of, Zip Code					of What Cou			
with th		5904 Justina D 11. Marital Status	12 Was Decedent	Ever in U	S 13 Was De		spanic Origin		fy Yes or No		Inited States 14. Race - American Indian, Black,			
death or iten	<u> </u>	1 Never Married 2 XM	1 X Yes 2	No	• If Yes,	specify Cubar	n, Mexican, Pi		White, etc.	ican				
rs after ural", miner	잙	3 Widowed 4 Div	orced If Yes, Giva Year or Dates:	nleted)	1 Ye	s 2 X No			of Business/					
72 hou n "nat al Exa		Elementary/Secondary (0-12)			during most of	of working life	. DO NOT us				O Basinossi	messimuustry		
within jiene.	Completed	12 17. Father's Name (First, Middle,			Crypt	o Offi				NSA				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than to event, the Medica	5 8	Charles Henry	, ,				18.Mother's N	,		Maiden Suri	name)			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State												
, MD and 2 sho ealth and cm 27 is	ŀ	Barbara Hall/W 20a. Method of Disposition		20b	Place of Disposition				ale		ation - City or	Town State		
Baltimore, permit. Pages I ar Department of Hes Important: If ites injury or other tr		1 X Burial 2 Cremation	_	ite '	crematory or other p	lace ukn	111	KIII-			nsvill	-ukn-		
altir mit. Pa partmen portan	ł	4 Donation 5 Other Sc 21 Signature of Funeral Service		TID	The second second	and Address						ice, Inc.		
LL.		Synne 11.	ne fruire		7400	Georg	zia Ave	e., 1	1.W. W	ash.,	D.C.	20012		
Physician Medical	J	23a. Per I. Enter the disease, or failure. List only one cause	on each line.				such as card	liac or re	spiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death		
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic (se						Journ Laboratory Control of the Cont		
		Sequentially list conditions, if any, leading to immediate	b	equence o	f)·									
	cause. Enter Underlying Cause (Disease or injury that initiated c													
e executed yan and rial - transit		events resulting in death) Last	d	querice o	· /·									
be execul sician and nurial - tra	2	UNPENDED	AMENDED 20b. coerFH. 1	0/17/	12:BMW.MbCc)								
876 tificate ng phy as the b	2	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom			eath 3	Ectopic pr	egnancy		23d. Da Mor	ate of delivery nth E) Day Year		
the death certificate by the attending physiched for use as the burner of the burner at the burner a	200		4 Pregnant at	time of de	ath 5 Other	(Specify)								
at the de lached is		Part II. Other significant conditi		but not re	esulting in the unde	rlying cause g	given in Part I.		23e. Did to	bacco use	contribute to	the cause of death?		
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - translation of Certification: T.O. B.C. Completed by the Brucial States and Completely filled in by the funeral director, page 2 should be detached for use as the burial - translation of the funeral director.	2	Diabetes mellitus, En	d stage renal diseas	е						2 🗸 No	3 Prob	ably 4 Unknown		
Records, The law requires ficate has been sign, page 2 should be									24a. Was a autop: perfor	sy		topsy findings available ompletion of cause of		
tal Rec	3	25. Was case referred to medical				00 Di	-f.D#- (OL	-11.	1 Yes	2 No	1 Ye	s 2 No		
Vital Rechysician: The this certificate all director, page	5	examiner? 1 ✓ Yes 2 No	Usesitel:	nt 2 🗸	ER/Outpatient 3[of Death (Ch	ursing H		Residence	6 Other	:		
ling Ph After t funeral	- -	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	ry ear)	28b. Time of Injury		ry at Work?		f. Describe h	iow injury o	ccurred			
Division ral or Attendir rs after death. al Director: A led in by the fu		Pend	stigation	un. At he	ome, farm, street, fa		Yes 2 No		Location (S	troot and N	lumbor or Bu	ral Pauto Number City		
Division o Hospital or Attending 24 hours after death Runeral Director: Aftered filled in by the fune			d not be mined (Specify)	ury - At no	ome, iarm, street, ia	ctory, office b	ouliding, etc.	281	or Town, St		number of Ru	ral Route Number, City		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	hysician: To the best of my											
To the Hos within 24 h		one) 2 Medical Exar 29b. Signature and title of certifie	miner:On the basis of exam and manner stated.	nination a	nd/or investigation,	in my opinion 29c. Licens		red at the	e time, date a			e cause(s)		
5		2-2	; = _			O.C.I					er 9, 2012	, buj, rear/		
	-	30. Name and address of person	•		,	L								
		Donna M. Vincenti, ME					Street, Ba	altimor	e, MD 212	223				
Stat Registra	_	31. Date filed (<i>Month, Day</i> , Year)	2012 Registrar	s olgnar	factor for the									

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Peath Physician/ Walter H. Hipkins 1904/16/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 214-36-7695 Days Hours Director 1 **X** M 2 □ F 0670271939 73 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 M Bayland Drive 21078 U.S.A. 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Laborer Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hipkins Agnes O. Smith 19a. Informant's Name/Relationship (Type, Print) 21078 MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau Dolores Hipkins (wife) 110 M Bayland Drive, Havre de Grace, 20a. Method of Disposition
1 ☐ Burial 2 ⚠Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State West Chester. RA Ferris & Co 10/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signat 123 S. Washington St, Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death probable Physician/ Medical resulting in death) Due to (as a consequence of **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🗌 Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death Month 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Vital Be 26. Place of Death (Check only one) Other: မြ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Division 1 Tyes 2 🗌 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) DO057223 completed cause of death (Item 23a) (Type, Print) Chesopeake Dr. Bel Aic, MD 21014 BarrasTo Mi

Registrar DHMH 17 Rev 06-2011

State

1 9 2012

TIDKIN , Walter

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day LUCRETIA MAE JESTER OCTOBER 13, 9:54 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min Director 214-34-5454 Usual Residence of Decedent 1 🗆 M 2 🗶 F 75 MARYLAND <u>04/18/1937</u> 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No GREENSBORO MD CAROLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21639 UNITED STATES 1340 GREENSBORO ROAD P.O. BOX 685 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Specify: WHITE 1 Yes 2 X No Specify: 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9 FACTORY WORKER FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOTTIE MAE SCOTT JAMES HARRISON ROSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 685
1304 GREENSBORO ROAD GREENSBORO, MARYLAND 21639 19a. Informant's Name/Relationship (Type, Print) ELIZABETH CARLISLE / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 10/20/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Such 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myberlini Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ronnen Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed DIARRETEL MAILITUS TYCE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 1 Yes 2 No Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No I Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERMONSEN

RAILFORD

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Are beiderson

October N. 2012

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			Registrar 1. Decedent's Name (First, Middle, Las	n#1		Cei	tificate	Of L	eatn			Reg. N	lo.		
	Physicia Medi		Andrew Lee Jones								2. Date of De		By, 20 12	3. Time of Death 3:11 P _M	
	Examir	ner	4a. Facility Name (If not institution, give Frederick Memoria	al Hospit			4b. City, To	leri	.ck			4	c. County of De Freder		
	Funeral Director		5 Social Security Number 6. Social Security Number 579-23-2466 1 Usual Residence of Decedent	ex 7. A	Age (In yrs. la 52	ast birthday) Yrs.	If Under 1	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth Year)	1960	Birthplace (State or Foreign Massachusetts	
	and show	5	10a. State 10b. County	1	10c. Cit	y, Town or Lo	cation			<u> </u>			l	10d. Inside City Limits	
	Manyl 28a-f	rect	Maryland Frederi	ck	Fr	ederio	ck							1 🕅 Yes 2 □ No	
	a or 2	Funeral Director	10e. Street and Number				10f. Zip (Citizen of What		
	h with	Der	1761 Algonquin Ro				217	/01				Ur	nited S	tates —————	
21215-0036	2 should be filed within 72 hours after death with the Maryland the end Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Evanther must be nuffied at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 X Yes 2 I If Yes, Give Year or Dates.	Int Ever in U.S. se? \[\begin{align*} \text{I3. Was Decedent of Hispanic (} \\ \text{If Yes, specify Cuban, Mexic} \\ \text{I \begin{align*} \text{Yes} & 2 \begin{align*} \text{X} \text{No} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \begin{align*} \text{Yes} & 2 \begin{align*} \text{X} \text{No} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \begin{align*} \text{Yes} & 2 \begin{align*} \text{X} \text{No} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \begin{align*} \text{Yes} & 2 \begin{align*} \text{X} \text{No} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify} \text{Yes}} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{I \text{Specify}} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} \\ \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} & \text{Specify} &					n, Puerto F	cify Yes or No- Rican, etc.)		Black, Wi	ace - American Indian, lack, White, etc. $_{ify:}$ B 1 a c k	
5-	72 hor	e de	15. Decedent's E (Specify only highest gra		13	(Give	lent's Usual kind of work	done d		t of workir	ng	16b.	Kind of Busines	ss/Industry	
212	within ygiene.	e Con	Elementary/Secondary (0-12)	College (1-4 or	r 5+)		nalyst						Medica	1	
Maryland	d be filed Jental H Irked ot tic even	To B	17. Father's Name (First, Middle, Last) JC Jones						18. Mother	er's Name ≘Z CC	Name (First, Middle, Maiden Surname) Coleman				
lan	1 and 2 should be if Health end Men Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)												
	1 and 2 of Health Item 27 other tr		_ Vallerie Jones /	Wife					Road	d, Fr	ederic	k, 1	Marylan	d 21701	
Baltimore,	- 0		1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Sam Houston Nat1. Cem. 2012 S									Location - City Antoni	or Town, State Lo,Texas		
Ball	permit. Page Department Important: I any injury o once,	21. Signature of Funeral Service Lifensee MO1473 Relement Agrees Basilford PA Funeral Home, 106 E. Church Street, Frederick, MD 21												21701	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that cause	ed the deati									Approximate	
	Physician/		Immediate Cause (Final disease or condition		phy1a	xis								Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a consequence of): Mild Chronic Obstructive Pulmonary Disease											
		er	Sequentially list conditions,	b. Mil			bstru	ctiv	e Pul	lmona	ry Dis	ease	2	5 Minutes	
	ted Insit	Examine	if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury		-	Etiolo	ov Und	cert	ain					3 Months	
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)9/	icate p phys	fedi		d										<u> </u>	
. Box 68760	Hospital or Attending Physicien: The law requires thet the death certificate be executed thours after death. Funerel Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of c	l death 3	Ectopic pre Other (spe		-				delivery Day Year		
P.0	thet the	by Pi	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying ca	use giv	en in Part I	l.	23e. Did t	obacco	use contribute	to the cause of death?	
ds,	quires an sign	pe F									1 🗆	Yes 2	2 X No 3 □	Probably 4 🗆 Unknown	
Š	aw red as be	Completed									24a. Was auto		24b. Were a	autopsy findings available o completion of cause of	
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Ę	Physion this or raidir	٠: ح	1 XYes 2 No 27. Manner of Death	1 Inpa		ER/Outpatier 28b. Time of			4 ⊔ Nu				6 ☐ Other (Sp	ecify)	
Division of Vital Records,	tending leath. tor: After the fune	Certificate:	1 K Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 SCould not be	(Month, D		injury	м 286	. Injury work?		- 1	8d. Describe I	now inju	ry occurred		
Divis	To the Hospital or Attending Physiciem: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		4 Homicide determined	28e. Place of In	njury - At ho etc. <i>(Specify)</i>		et, factory, o	office		2	8f. Location (S City or Tov	Street ar vn, State	nd Number or F e)	Pural Route Number,	
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one) 3 Certifying Nurs	ner: On the basis of	examination	and/or invest	igation, in my	opiniou v	 death oc 	curred at t	he time, date a	and place	e, and due to the	e cause(s) and manner stated	
	To the within 2 To the comple	-	29b. Signature and title of certifier	27			29c. l	icense	number			29d. Da	ate signed (Mor	nth, Day, Year)	
			pullins	Nan	- K	0.0.	H.	3 71 8	38			Oct	ober 10	, 2012	
	OX		30. Name and address of person who c William Swann, D	O Fort D	etric	k. 143		ter	Stre	et, I	rederi	ck,	Maryla	nd 21702	
	Stat Registra		31. Date filed (Month, Day, Year) 6 2(32. Flegist	trar's Signat	uro.s	arkel								

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or									_	ible.			
		For State		State of	of Mar	yland / I		artment of		and N	/lental Hy		20	12	35443		
	-	Registrar 1. Decedent's Nam	e (First, Middle	e. Last)			Cer	tificate of	Death		2. Date of D	Reg. N	0.C U	1 4	3. Time of Death		
Physicia Medic			, ,	trimour "	JENI	LZ NS	W				Month	D	ay	Year	O > 17 M		
Examir				, give street and nur		-		4b. City, Town, o				4		c. County of Death			
		HOWARD ICUNTY STUFRAL HOSPITAL COLUMBIA, MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of E											110	WAR			
Funeral Director		214-64-3	250	6. Sex 1			Yrs.	Months Days	Hours	Min.	8. Date of Bi	av.1 ^y 95	4	9. Birth	place (State or Foreign ntry) MD		
und show at	ō	Usual Residence of 10a. State	10b. County		10	Dc. City, Towr	n or Lo	cation				10d. Inside City Limits					
Maryla 28a-f s	rect	MD	Howard	đ		Elli	.cot	t City							1 ☐ Yes 2X No		
h the l	Funeral Director	10e. Street and Nur 300 Kat		Dl ago				10f. Zip Code	_			itizen of W					
th wit	ner		uerne	12. Was Dece	odent Ever	rin II C	12 1	2104 Was Decedent of F		ain? (Cno	oif. Voc or No		nited States				
er dez or ite miner	by F	11. Marital Status 1 □ Never Marr	ied 2 🗆 Mar	ried Armed Fo	orces? 2 🕱 No	111 0.3.	l l	f Yes, specify Cub		k, White,	can Indian, etc.						
ursaff tural", al Exa	ted	3 🗌 Widowed		Teal OI D			1	I ☐ Yes 2 🔀 No	Specify:	Whit	e						
72 ho n "nat Aedica	Completed		ecify only high	nt's Education est grade completed	n)	16a.	Give I	isiness In	dustry								
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tal Hy ed oth event	To Be	17. Father's Name (,	,								2012 Hanover, MD H. Witzke's Family FH Inc. e Ellicott City MD 21043					
d Men d Men marke natic	-	William 19a. Informant's Na		r Jenkins	, III												
12 shouth and the sho				on/sister	-			ng Address (Street Meadowc)									
of Head of Head fitem		20a. Method of Disp	position					sition (Name of natory or other pla	cal		Date	1					
ment ment tant: I		1 🗆 Burial 2 4 🗆 Donation	5 Other (3 ☐ Removal from	State		ent	er of MD		10/2	7/2012	Ha	anove	er, M	ID		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service I	_icensee			22 /11	Name and Addre	ss of Facilit	_у нат. ia Р	ry ike	Vitz]	ke's	Fami	ly FH Inc.		
_		23a. Part 1, Enter t	the disease,	omplications that	Caused the	e death. Do n	_				- علد اساد	LICO	tt C1	ty M	Approximate		
Physician/		shock, or hear Immediate Cause (rt failure. List o Final	only one cause on ea	ach line.										Interval Between Onset and Death		
Medical Examiner		disease or condition resulting in death)) II	Due to	(or as a co	onsequence of	of):	N (AND	4716	1)=,	7117						
Examiner	<u>-</u>	Sequentially list co	nditions,					NFARCTI	44					_			
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be executed sician and burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):															
cate be physicia the bur	Physician/Medical	d															
sath certifica attending p I for use as t	/Me	IF FEMALE:		23c. If yes, out	tcome of r	oregnancy											
eath c	iciar	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live 4 Preg	Birth 2 Ĺ nant at tin	Fetal death		Ectopic pregnan Other (specify)	су				23d. Date Mor		ery Day Year		
the de by the	hys	9 Unknown		9 🗆 Unki	nown												
iires that the dea signed by the a ld be detached f	þ	Part II. Other signif	icant condition	ons contributing to d	leath but r	not resulting i	n the u	nderlying cause gi	ven in Part	I.					ne cause of death?		
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e law e has k ge 2 s	dwo					-					24a. Was auto perf	opsy ormed?	p	rior to co eath?	psy findings available impletion of cause of		
sician: The law certificate has b irector, page 2 s	Be Co	25. Was case referre	ed to medical			,		26. P	lace of Dea	th (Check	1 Yes	2 🖺 N	lo 1	☐ Yes	2 No		
hysici his cer I direc	To B		No			2 ER/Ou	ıtpatien	_ Oth	er:		me 5 \square Res	idence	6 🗌 Othe	r (Specify	')		
ding Physi th. After this c funeral dire	ate:	 Manyler of Death Natural 	5 🗌 Pendir	19	of injury oth, Day, Ye		ime of njury	28c. Injur worl	?		28d. Describe	how inju	ry occurre	d			
al or Attendii s after death. I Director: Af d in by the fu	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investi	not be	of Injury -	- At home, far	rm, stre	M 1 L	Yes 2 L		28f. Location	Street ar	nd Numbe	r or Rural	Route Number,		
tal or , s after s all Dire		4 Li Homicide	determ		ing, etc. (S						City or To				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 (Check 2	Certifying Medical B	Physician: To the bear	est of my	knowledge, on the state of the	death o	occured at the time	e, date and on, death or	place, an	d due to the ca	ause(s) a and place	nd manne e, and due	r as state to the cau	ed. use(s) and manner stated		
the lithin 2 the lomple	Me		Certifying	Nurse Practioner:					e time, date			he cause	(s) and mai	nner as st	ated.		
FSFŏ		11	X B	And.	·M	· O .		Zoo. Elogis	112/1				ate signed				
		30. Name and addre	ess of person	who completed caus	se of death				اعاديا					, , ,	· · · ·		
10		Espert	Ashdor			N.D.	57	SS (EDA	RIA	NE	(thum	STO	my, My	16 0	1044		
Stat Registra		31. Date filed (Monti	CT 22	2012	egistrar's	Signature	Solo	ares									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 11:55 P_M October 7 2012 2012 Stevie Ann Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Min. Hours N/A Director 1 🗆 M 2 🗓 F 20 10/7/2012 Maryland 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Bowie 1 Yes 2xXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5202 Church Road 20720 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 X Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen Gregory Johnson Andre Jo Margaret Gentile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5202 Church Rd, Bowie, MD 20720 Stephen Johnson - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State i i 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or Baltimore Crematory 10/11/2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Mugd 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Extreme Prematurity Examine signed by the attend be detached for u

Physician Medical Examiner

> use as the burial-tran ding physician

Hospital or Attending Physician: The law requires that the death certificate being hours after death.
Funeral Director: After this certificate has been signed by the attending physicis

funeral director,

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical

resulting in death)												
resulting in death)	Due to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):											
resulting in death) Last	Due to (or as a consequence of): d.											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year									
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown									
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No									
25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)										
1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing	Home 5 Residence	6 ☐ Other (Specify)									
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	ury occurred										
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause(s)	and manner as stated.									

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Annapolis, MD 21401

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

within 24 hours a

2001 Medical Parkway

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Richard Welch

OCT 15

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 10 Day 2012 ar Month. Physician/ 9:23 pm_M Edgar B. Justice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Davidsonville 1098 Galway Road Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthdav) Funeral 219-07-0153 1 X M 2 □ F Director 09/18/1917 Baltimore, MD 95 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-1 si ner must be notified MD Davidsonville 1 Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 USA 1098 Galway Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. "natural", or itel Armed Forces Black, White, etc 2 No ve WWII þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self Employed Contractor other Be Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked of rother traumatic ever Carrie A. ပ John Adam Justice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health a : If item 27 i 3 Ritchie Road Annapolis, MD 21409 Mary Pat Justice/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory or other place ō Glen Burnie,MD Department of Important: If any injury or once. 10/12/2012 Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hyperten as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Dav Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred al or Attending F s after death. I Director: After t 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

To the within 2

only one)

31. Date filed (Month.

30. Name and

29b. Signature and title of certifier

address of person who corp

DHMH 17 Rev 06-2011

leted cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1460 Ritchie

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RICHARD CLIFFORD JOHNSON /<u>14/2</u>012 4:25 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 11/4/1946 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign Months Days Hours Min. Country Director 1X M 2 □ F ΪŇ 578-64-9848 65 or 28a-f shov r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown Y Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20874 USA 18003 Mateny Road, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) filed within 72 al Hygiene. il other than " College (1-4 or 5+) Elementary/Secondary (0-12) Bricklayer -Construction Contractor e 1 and 2 should be filed wit of Health and Mental Hygle If item 27 is marked other ir other traumatic event, <u>tt</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic Juanita Poree <u>Clifford</u> Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vienia Johnson/wife 18003 Mateny Rd., #315, Germantown, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/22/2012 Cremation Ctr of MD Hanover, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 2.1 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 4 ☐ Pregnant at time of death g ☐ Unknown Day signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si
completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 X No 1 Yes 2 X No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Yes 2 🖾 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) 10/14/2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu, Joseph, 6000 Muncaster Mill Road, Rockville, MD 20855

State

Registrar

31. Date filed (Month, Day, Year)

OCT

1 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10/9/2012 12:41 рм ANTONIO DARNELL JACKSON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days Hours Director 1 M 2 | F 220-70-5292 55 11/28/1956 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-f show any injury of other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Dickerson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20842 20800 Big Woods Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Yes 2 □ No
If Yes, Give 1975–1980
Year or Dates: Black, White, etc. Never Married 2 ☐ Married ğ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper Lawn Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Wilhemina Mercer Charles Raymond Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Portia Jackson/sister 20800 Big Woods Road, Dickerson, MD 20842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Md Cremation Center 1 Burial 2 K Cremation 3 Removal from State Hanover, MD 10/19/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the discount of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) povolemic Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit Alcohol an that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **Director:** After this certificate I 1 ☐ Yes 2 ☐ No ☐ Yes マーのた Por Cy Division of Vital I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2.X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C completely filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Ctr Dr Rockville MD 20850 9901 + MD 31. Date filed Month, Day, Year OCT 17 32. Registrar's Signature State 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Pay 2012 Faye R. King 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oakland Garrett 222 Nazelrod Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

WV 7. Age (In vrs. last birthday) **Funeral** Days (Month, Pay, Year) 02/07/1929 216-80-5573 **Director** 83 1 M 2 P 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Direct 1 🗌 Yes 2 🔀 No Oakland MD Garrett ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21550 222 Nazelrod Road **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ David Johnson Lucinda Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Nazelrod Road, Oakland, MD 21550 David King / Son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/22/2012 Deer Park, MD Deer Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Į, Burdock-Fredjock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 4 No 1 Tes 24 hours after death.
Funeral Director: After this certificetely filled in by the funeral director, 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 3 🗆 Certifying Nurse Provitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) D422464

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 2 2012

32. Registrar's Signature

30. Name and address of person who completed cay

2. Registrar's Signature

e of death (Item 23a) (Type, Print)

Sotiere Savopoulos 255 North Fourth St, Suite 100 Oakland, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samuel Wilkins Kidder 2012 2:10 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery House Casev Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 552-40-3407 Director 75 1 🖾 M 2 🗆 F Yrs 11/22/1936 California Usual Residence of Deced 10a. State 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director Silver Spring MD Montgomery 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 2204 Coffeewood Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Pharmacist 5+ t. Page 1 and 2 should be filed with them of Health and Mental Hygien trant: If item 27 is marked other 1 jury or other traumetic event, them is the standard of the standard or other traumetic event, the standard or other traumetic event, the standard or other traumetic event, the standard or other traumetic event, the standard or other traumetic event, the standard or other traumetic event, the standard or other traumetic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Palmtag Donald Kidder Avis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Veronica M. Kidder 2204 Coffeewood Court, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 10/18/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cole Funeral Services. P.A. Signatur of Fundral Service Lices 4110 Aspen Hill Rd. #100, Rockville, MD 20853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complication of Subjural Hematoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): nma Examiner Multiple Falls Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Alzheimer's Dementia Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 🔀 Yes 2 🗆 No Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) Casey House မ 1 Inpatient 2 ER/Outpatient 3 DOA Hośpice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural Unk 1 ☐ Yes 2 ☑ No 0.11 2012 2 X Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Ryral Route Number, City or Town, State) O MUTE 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maker as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/14/2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 6001 Muncaster Mill Road, Rockville, MD 20855 Bindu Joseph, M.D. OCT 1 9 2012 31. Date filed (Month 32. Pagistrar's Signature State Registrar

Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 Physic Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaria Director, After this certificate has been signed by the attending physician and complated filled in by the financial director mana? Should be detached for use as the buriel transit Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner Martha Ann Lansberry Kinkead 4a. Facility Name (if not institution, give street and number) Golden Living Center Funeral Director 5. Social Security Number 208-30-1788 1 M 2 M F T M M M M M M M M M	Reg. No. ath Day Tear 13, 2012 3. Time of Death 3:00 P. M 4c. County of Death Frederick th X Year 1940 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian,
Physician/ Medical Examiner The content of the con	3. Time of Death 13, 2012 3:00 P. M 4c. County of Death Frederick th (x, Year) 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 X Yes 2 \(\sqrt{No}\) 10g. Citizen of What Country? United States 14. Race - American Indian,
Medical Examiner Martina Ann Lansberry Kinkead October October 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Golden Living Center Frederick 5. Social Security Number 6. Sex $1 \subseteq M$ And M An	4c. County of Death Frederick th (x, Year) 1940 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian,
Golden Living Center Frederick Funeral Director	Frederick th (Year) 1940 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 📉 Yes 2 🗆 No 10g. Citizen of What Country? United States 14. Race - American Indian,
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year I If Under 24 Hrs. 8. Date of Birthday) 208-30-1788 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Months Days Hours Min. 02/17/1	th (Y Year) 1940 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian,
Director 208-30-1788 1 M 2 M F 72 Yrs. Mortins Days Hours Min. 02/17/1	10d. Inside City Limits 1 🗶 Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian,
10a. State 10b. County 10c. City, Town or Location MD Frederick Middletown 10f. Zio Code 10f.	1 🗶 Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian,
No. Street and Number 106. Street and Number 107. Zin Code	10g. Citizen of What Country? United States 14. Race - American Indian,
	United States 14. Race - American Indian,
8 71 Boileau Ct. 21769	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11 Never Married 2 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13 Widowed 4 M Divorced 14 Yes 2 No Specify:	Black, White, etc. Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business Industry
The state of the s	Health Care
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	
Grace McKean	,
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	
Laura Kinkead / daughter 1801 Spruce Peak Way, Frederi	
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bradford Cemetery 10/19/2012	-
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer F 1621 Opossumtown Pike, Fr	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arms shock, or heart failure. List only one cause on each line.	rest, Approximate Interval Between
ysician/ Immediate Cause (Final disease or condition MELANOMA	Onset and Death
Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
The state of the s	
d	
The part of the pa	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tol	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
24a. Was a autopped of the part of the par	prior to completion of cause of death?
To the second s	2 No 1 Yes 2 No
examiner? 1 Yes 2 No Hospital: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	lence 6 Other (Specify)
28d. Describe hore of Dean 1 28d. Describe hore of Dean 1 28d. Describe hore of Dean 2 28d. Describe hore of Dean 3 2 27d. Manner of Dean 1 28d. Describe hore of Dean 2 28d. Describe hore of Dean 3 2 28d. Describe hore of Dean 3 2 28d. Describe hore of Describe hore of Dean 3 2 28d. Describe hore of Dean 3 2	ow injury occurred
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau	nd place, and due to the cause(s) and manner stated.
29b. Signature and time of certifies 29c. License number D 47 9 5	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1876- A. KAZMI MD 814 Toll House Ave F	10-16-2012 releach. Mb 2170
State Registrar 0CT 17 2012 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6. 2012 8:37 PM Roy F. Kinard, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 7, 1931 9. Birthplace (State or Foreign Country)
Alabama 7. Age (In yrs. last birthday, **Funeral** 421-34-7296 Director 1X M 2 | F 81 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at by Funeral Director notified 1 X Yes 2 No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò "natural", or items 23a or USA 21401 6 Randall Court Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White If Yes, Give 1955-81 3 X Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry other than College (1-4 or 5+) Elementary/Secondary (0-12) Public Health Service Pathologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even မ Lula Ray Brackin Roy F. Kinard, Sr. 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number City or Town State, Zip Code)
Randall Court, Annapolis, MD 21401 Winston Kinard - Son Health a Department of Healtl Important: If item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Anne's Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/12/2012 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No 1 Inpatient 2 Date of injury (Month, Day, Year) ဂ္ 1 Tyes ER/Outpatient 3 DOA filled in by the funeral Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

68760

Box (

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:56 A Issie Jack LUSTIG Ototober 12, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death
Montgomery Bethesda Suburban Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28, 1934 Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Hours 091-30-7607 1 X M 2 🗆 F **Director** Canada 78 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🖔 No Silver Spring Maryland Montgomery 9 10e. Street and Number 10g. Citizen of What Country?
United States must be 23a 20906 3330 N. Leisure World Blvd., #1027 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 Yes fif Yes, Give _2 X No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🕅 No Specify: Completed 3 Divorced 4 Divorced Year or Dates ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Furniture Management/Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Anna Pell 2 Jack Lustiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 4413 Prince Road, Rockville, MD Steven Lustig, Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Judean Memorial Gardens 10/14/12 Olney, MD 21. Signature of Funeral Se vice Licensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. E ter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Ventricular Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death V 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 ☐ Yes 2 ☐ No Yes 2 Y No R 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28a. Date of Injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation

Box 68760 P.O. Division of Vital Records, ed in by the funeral e Hospital or Attending P 124 hours after death. e Funeral Director: After t 24 hours a within 2

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29c. License number October 12, 2012 D 36797

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Alan Sheff, M.D., 10215 Fernwood Road, Bethesda, MD 20817

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012er October 15% Physician/ Albert LEVINE 5:45 A.M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda 4c. County of Death Montgomery **Examiner** Suburban Hospital Social Security Number 079-20-2145 If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours August 12, 1927 Brooklyn, NY Director 1 🕅 M 2 🗆 F 85 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State by Funeral Director notified Potomac 1 Yes 2 No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 50 pe 20854 USA ms 23a (must be 7629 Fontaine St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or iter edical Examiner Black, White, etc. 1 X Yes 2 No Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. I other than " vent, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Textile Salesman Be 8. Mother's Name (First, Middle Maiden Surname) Sally Bree 17. Father's Name (First, Middle, Last) marked (Louis ၉ Levine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S. 20854 7629 Fontaine St., Potomac, MD item 27 other tra MIchael Levine / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Oct. 16, 2012 Clarksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licenses 254 Carroll St., NW, Washington, DC 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 13 day Immediate Cause (Final Bleed Physician/ Intracerebral disease or condition resulting in death) Medical Due to (or as a consequence of) MD DME **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) 292 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exitin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burners. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at Natural XAccident 5 Pending Fall 0ct.2,2012 1 ☐ Yes 2 X No 1:00 p M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Home Potomac, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D65234 Oct. 15, 2012 $\mathsf{M.D.}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St., Meyer 8-181, Baltimore, MD 21287 Anand Germanwala, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 17 2012 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 15, 2012 Anh Lan La 4:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10800 Georgia Avenue, Apt. Silver Spring Montgomery 313 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 218-04-1049 Director 1 □ M 2 🖾 F May 5, 1929 Vietnam 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo other treumatic event, the Medical Examiner must be notified MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ត 10g. Citizen of What Country? Funeral 23a 10800 Georgia Avenue, Apt. 313 20902 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Special Asian If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pege 1 and 2 should be fill tment of Health and Mental tent: If item 27 is marked မ Duc Kham La Nhung Thoai Ngo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie V. Thach/Daughter 3800 Powell Lane, Unit 826, Falls Church, VA 22041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of h Importent: If ite eny Injury or ot 1 X Burial 2 Cremation 3 Removal from State Oct 2072 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, MD Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physician end for use as the burlal-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown To the Hospital or Attending Physicien: The iew requires that the dea within 24 hours after death.
To the Funerial Director: After this certificate has been signed by the e completely filled in by the funerial director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2XXNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 🖺 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 16, 2012 D54486

DHMH 17 Rev 06-2011

State Registrar

P.O. Box 68760

Division of Vital Records,

7505 New Hampshire Ave., Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huyanh Ton, MD

31. Date filed (Month, Pay, Year)

Amend	1 #26 pe	r P	HY t. 10-16-12	Pleas	е Туре о									Legib	le.	
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0	Examiı		4a. Facility Name (if	Mud	Ly C.	eek		1	City, Town, o	~ 1.	RIV			County of	A	<u> </u>
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr ※ Widowed	ried 2 Married	12. Was Dec Armed F 1 X Yes If Yes, G Year or I	orces? 2 \(\sigma\) No ive	in U.S. Korea		ecedent of H specify Cuba es 2XXNo				14. Race - American Indian, Black, White, etc. Specify: White			
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Division of Vital Records, P.O. Box 68760	nat the death certilicate be ed by the attending physicic detached for use as the bu	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		Birth 2 🗔 gnant at tim	Fetal death	3 Ecto 5 Othe		ÿ			2	3d. Date o' Month	f delivery Da	
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of Vi	r this c eral dir	<u>은</u>	1 Yes 2 2 27. Manner of Death	X io	1 28a. Date		2 ER/Out		DOA Othe	4 ∐ Nu	ursing Hor	ne -5 Ñes i 8d. Describe l	dence 6	Other (S	neciful	esidence
on c	eath. or: After '	Certificate:	1 Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investigation	on	nth, Day, Yea	ar) in	jury M	work			ou. Describe i	iow injury	occurred		
Division of Vital Records, P.O.	s after da al Directo		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determined	28e. Place	e of Injury - / ling, etc. (Sp	At home, farn ecify)	m, street, fac	ctory, office		2	28f. Location (S City or Tov		Number or	Rural Ro	oute Number,
the Hocori	vithin 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	(Check 2	Certifying Phy Medical Exam	niner: On the ba	sis of examir	nation and/or	investigation	, in my opinio	n, death oc	curred at 1	the time, date a	and place,	and due to t	the cause	(s) and manner stated.
, s			29b. Signature and t	title of certifier	PC	2) ind	0	29c. License	number D 6	05	et		signed (M		
	\$1/2°		30. Name and addre	ess of person who	completed cal	se of death	(Item 23a) (T	ype, Print)	69	5 1	A	nerio	· 2A	21	03	5—
	Stat Registra		31. Date filed (Month	OCT 16 2		Registrar's S	ignature	bar	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Dorothy J. Moon 11:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett 400 Glades Square #27 Oakland If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Pay, Year) 01/13/1927 Director 432-38-7094 1 🗆 M 2 🔀 F 85 Yrs Usual Residence of Deced in than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Oakland MDGarrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 USA 400 Glades Square #27 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 M Widowed 4 □ Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 11 Be Depertment of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other trainman. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Mary Elizabeth Crisp William J. Kirksey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Kirksey, Jr. / Brother 6189 Front St, PO Box 76, Falcon, NC 28334 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/23/2012 Oakland, MD Garrett County Memorial Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MUDGARd disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and I for use as the burial-transit Exami that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2' No 9 Unknown Month Day Year signed by the a ld be detached f Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ abdominal astic aneucpon, unphysem 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed heal Vascular discuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 1 Yes 2 No after death Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ho completed cause of death (Item 23a) (Type, Print) 30. Name and add e

Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 22, Casper Charles Murphy 2012 07:05 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mount Airy Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director <u>215-36-7100</u> 1 XM 2 🗆 F 89 Maryland April 11 1923 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick I jamsville 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10701 Fingerboard Road 21754 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Il Hygiene. I other than "natural", 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Murphy Mamie Eugenia Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryanne Spencer/ Daughter 10701 Fingerboard Rd., Ijamsville, MD 21754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If any injury or once. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 10/26/2012 Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1646 106 E. Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final postate Physician/ dvanced disease or condition resulting in death) ear Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No. Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhumn 31. Date filed (Month, Day, Year)

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35459 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 October Jerome Moore 0605 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Elkton Care and Rehabilitation Ceci1 E1kton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days Hours Min. Director 22-18-6996 1 🛛 M 2 🗆 F Usual Residence of Decede 80 NOV 8, 1931 Delaware parmit. Paga 1 and 2 should ba filed within 72 hours aftar death with the Maryland Depentment of Health and Mantal Hygiana. Important: If itsm 27 is merked other than "natural", or itsms 23a or 28a-f show any injury or other traumatic event, the Modical Examination of the notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2938 Old Elk Neck Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1951 1 M Yes 2 □ No 1955 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1955 1 ☐ Yes 2 1 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fieldman **Utility** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Jerome Moore Catherine Heisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice D. Moore/Wife 2938 Old Elk Neck Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 24 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cremation Services 2012 Wilmington, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CEREBLO Vasua Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events <u>ē</u> Due to (or as a consequence of): Exami ate has bean signed by tha ettanding physician end paga 2 should ba datached for use as tha burlal-trensit or Attending Physician: The law requires thet the deeth cartificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe after death.

Director: After this certificate Yes 2 N filled in by tha funaral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work≀ 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours of To the Funeral Di complataly filled I Medical 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier P. V Naye 10/23/1 Do 65733 stret, ELKTON, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21921 East High V. PULA 126 A NARAYANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2012 Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{Year} October 20, 12:47 P Donald Lester Manning Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hancock Washington 14227 Reel Road Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 216-38-1103 **Director** 1 🕅 M 2 🗆 F 72 Yrs. 05/23/1940 MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 X No MD Hancock Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 14227 Reel Road 21750 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ō 1 X Never Married 2 Married þ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Callege (1-4 or 5+) 11 Laborer Agriculture Be Department of Health and Mental H Important; If item 27 is marked ott any injury or other frame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mable Paylor William Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14429 White Oak Ridge Hancock, MD 21750 Ruby Manning/Sister-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10/24/2012 Smithsburg, MD 21. Signature of Juneral Service Licens 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List in the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiovascula disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical that the death certificate be t phys the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ed by the a detached f 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural 5 \square Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Records, Division of Vital within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Registrar

only one) 29b. Signature and title of certifier

e cent

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

tarcock.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ REBECCA MADELINE NICHOLSON **OCTOBER** 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KENT 100 KENT MILL DRIVE MILLINGTON 7. Age (In yrs. last birthday) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 M 2 XF Days Hours Director 80 Yrs. 01/30/1932 MARYLAND 218-24-7470 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location must be notified at Director MD KENT MILLINGTON 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 100 KENT MILL DRIVE 21651 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give ıral", or item i Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) POSTAL SERVICE POST MASTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ္ JOHN EDWARD O'NEAL **ELLA MEEKS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 CHRIS CLOUGH / DAUGHTER 100 KENT MILL DRIVE MILLINGTON, MARYLAND 21651 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) POND CEMETERY 10/11/2012 STILL POND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a Ant 1. Enter the disease, or complications in shock, or heart failure. List only one cause or rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Dun to (or és a consequence of) Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant Box (23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Records, Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autons performed Yes 2 Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) of Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 Pendina work? 1 ☐ Yes 2 ☐ No Division illed in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of de h (Item 23a) (Type, Print)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Day

Onset and Death

1 Yes 2 X No

9:50 PM

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Box 68760

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			State Registrar				-	rtificat					Reg. No	0 0 1	2	35463	
Ħ	Physicia Media		1. Decedent's Nam JAMES LE		.ast)							2. Date of De Month		, 2012 ^{Ye}	ar	3. Time of Death 2:35p M	
-	Examir		4a. Facility Name (i Suburban			nber)		1		Location	of Death		4c	. County of E			
mande	Funeral		5. Social Security N		. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth							ontgamery 9. Birthplace (State or Foreign		
	Director ≩		523-48-12 Usual Residence		1 🖾 M 2 🗆 F	7	71 Yrs.	Months	Days	Hours	Min.	2/24/	1941	- a	Countr	y)	
	aryland e-f sho fled at	Funeral Director	10a. State MD	Montgon	ne r v		10c. City, Town or Local Potomac		cation							d. Inside City Limits	
	tha Mi	I Dir	10e. Street and Nu					10f. Zip Code					10g. Ci	tizen of What	Count	1 XYes 2 No	
	h with	nera	7953 Tur	ncrest D	rive			208	20854				USZ	A			
920	ba filad within 72 hours after death with tha Meryland antel Hygiene. kad othar then "neturel", or itams 23a or 28e-f show ite othar the Medical Evanire in ust be inclified at its evant, the Medical Evanire in ust be inclified at	Completed by Fu	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 □ Married 4 □ Divorced	Armed Fo	edent Ever in l prces? 2 No ve ates. 1958		If Yes, spe	Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:					14. Race - A Black, W Specify: W	tc.		
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working the state of the											ina	_	and of Busine				
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aryk K	should ba file n and Mantel I 7 is merkad o reumetic eva		19a. Informant's N				10h Mail	ing Address	o (Strout o			Henders		T	7: 0		
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Baltimore, Maryland 21215-0036			1 ₹ Burial 2	Cremation 3 5 Cother (Spe	☐ Removal from	State	. Place of Disp cemetery, cre arklawn	matory or o	other plac			Date 6/2012		-			
Ball	142 Burial 2 Cremation 3 Removal from State Cemetery, Crematory or other place) 4 Donation 5 Other (Specify) Parklawn Cemetery 10/16/2012 Rock 22. Name and Address of Facility Snow en Funeral Service Cleensee 22. Name and Address of Facility Snow en Funeral 246 N. Washington St., Rockvi													20850			
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. Box 68760	ital or Attending Prysicien: The law requires that the daeth certificata is In Inter death. In Director, Affar this certificate hes been signed by the ettending physical director, Affar this certificate been signed by the funeral director, pege 2 should be detached for usa as the line in by the funeral director.		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, out 1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	Birth 2 ☐ Fe nant at time o	etal death 3		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year			
P.O.	s that the gned by be detac	by Pr	Part II. Other signi	licant conditions	contributing to d	leath but not r	esulting in the	underlying	cause giv	en in Part	l.					cause of death?	
rds,	require been signature	eted										1				ably 4 Unknown	
Division of Vital Records,	The law ate hes bege 2 s	Completed									 -	24a. Was auto perfo	psy ormed?	prior death	to com	sy findings available pletion of cause of	
Ta .	Iclen: Sertific 'ector,	윤	25. Was case referr examiner?	-	Hospital:					ace of Dea	th (Check						
<u> </u>	Phys r this aral dii		1 Yes 2	X-No h	28a. Date		ER/Outpatie		OA Othe	4 ⊔ N		me 5 Resi			ecify)		
ion	ttending death. tor: Afta the fune	Certificate:	1 ♣ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigati 6 ☐ Could not	ion	th, Day, Year)	injury	м	work	Yes 2□		28d. Describe I	now injury	y occurred			
Divis	ital or Al irs after rel Direc llad in by		4 Homicide	determine	ed 28e. Place buildi	ing, etc. (Spec						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
:	to the Hostra after death within 24 hours after death within 24 hours after death. To the Funerel Director; After this certificate hes complately filled in by the funeral director, pege 2	Medical	(Check 2	Certifying Pt Medical Example Certifying No.	miner: On the bas	sis of examinati	ion and/or inves	stigation, in	my opinio	n death or	courred at	the time date a	and place	and due to ti	ha carre	a/e) and manner etated	
											te signed (Mo		ıy, Year)				
			30. Name and addr					Print)					TU/.	11/201	۷		
			Dan M. Da	mila, 86	500 Old (Georget	town Ro	ad, B	ethe	sda,	MD 2	0814					
	Stat Registra	. .		TT 1720)12 32 R	egistrar's Sign	ature 40	Made									

Owens, James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ OCTOBER 3, 2012 2:05 A M WILLIAM WILBUR PRICE, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S HOSPICE OF QUEEN ANNE'S, CENTREVILE Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours 73 Yrs. 07/29/1939 MARYLAND **Director** 216-38-7885 Usual Residence of Decedent or 28a-f show notified at 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **OUEEN ANNE'S** CHURCH HILL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 724 JOHN POWELL ROAD 21623 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 AGRICULTURE FARMER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FLOYD C. PRICE GRACE EVA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. LUCILLE PRICE / WIFE 724 JOHN POWELL ROAD CHURCH HILL, MARYLAND 21623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Important: If ite any injury or oth Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
Signat | ed | Funeral Service Lice | 1 SUDLERSVILLE CEMETERY 10/07/2012 SUDLERSVILLE, MARYLAND FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 236 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate
Interval Between
Onset and Death
2 4 eurs Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No A

9 Unknown Ske Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Division of Vital Records,

2

State

Registrar

Medical

Natural

4 Homicide

29a. Certifier (Check

Accident Suicide

29b. Signature and title of certifie

Ross m.D. 31. Date filed (Month

5 Pending

Investigation Could not be

determined

DO M.D

D001703C

1 Yes

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 🗌 No

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

516 Washington Are. Chartestown Mid 21420 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER JAMES S. POTTER, JR. 2012 5:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Davidsonville **Examiner** 4c. County of Death Anne Arundel 3467 Godspeed Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. 578-48-4290 1**X**XM 2 ☐ F Director 74 Yrs. August 27,1938 Washington, DC Usual Residence of Decedent er then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Davidsonville Maryland Anne Arundel 1 Yes 2 W No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 3467 Godspeed Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 🙀 Married ۾ Maryland 21215-0036 1 Yes 2 No Specify White Completed Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) JB Kendall, Inc. President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked James Stanley Potter, Sr. Helen Seiler permit, Pege 1 and 2 should be Department of Health and Men Importent: If item 27 is marke eny Injury or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Potter/Spouse 3467 Godspeed Road, Davidsonville, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/15/12 Edgewater, Md. 21037 Kalas Crematory 21. Signature Appropriate Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Mar 2973 Solomons Island Road, Edgewater, Md. 21037 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician/ Multiple Myelona disease or condition Medical resulting in death) Examiner ACHEXIA-FA Sequentially list conditions, Due to for as a consequence on if any leading to immediate cause. Enter Underlying RENAL FAILURE as the burial-transit Cause (Disease or injury that initiated events Exa and Due to (or as a consequence of) resulting in death) Last Physician/Medical 4eans thet the death certificate be ATHEROSCIENOTIC CARDIOVARCULAR Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 0 in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, DIABETER MELLITUS, HOENLAIDENIA Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? this certificate 1 Yes 2 No Division of Vital **Physiclen:** director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 200110 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospitel or Attending Pl within 24 hours after decth. To the Funerel Director After the completely filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending 1 🔼 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, P D31997 (mu m) 10/15/ 2012

State Registrar

CHIOH

ANDRON GORDON AD 2003 MEDICAL PANY SE 100 ANNAPOLIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 16 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#285 State per MD FCHD KS 10/19/12 Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROHRER Month ROBERT 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health System Cumberland Garrett . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216-22-8736 84 **Director** 1 X M 2 □ F March 28,1928 Maryland 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland 1 X Yes 2 No Frederick Frederick 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 208 Norva Ave. 21701 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1946

If Yes, Give
Year or Dates. — 1947 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dale В. Rohrer Ima We1ty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Rohrer / Wife 208 Norva Ave./ Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cem. 10/16/2012 Frederick, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Priver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only one cause on each line. Immediate Cause (Final 2 Grain stem hemorrhage Physician/ cerebral disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 61/61 the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ası use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending slipped on ice 10 11/12 1 🗌 Yes 2XXNo hin 24 hours after death the Funeral Director, Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Plac of Jury - At home, farm, street, factory, office building, etc. (Specify)

Peep Creek La 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) + County eep creek Lake Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within To the

State Registrar

31. Date filed (Month

MILTON

29b. Signature and title of certifier

Lum 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Willowbrook RN Suite 500, Cumb. MD 21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis, Anne Arundel Medical Center MD Anne Arundel . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Shanghai, China Social Security Number 8. Date of Birth Funeral 1 🗆 M 2 🔽 Days Months Hours Min 1-30-1934 578-78-7899 Yrs Director China Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Anne Arundel MD Annapolis 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 800 Bestgate Road 21401 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Asian Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Wedding Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked o any injury or other traumatic ever ဂ္ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Youskauskas/daughter Crofton, MD 21114 1742 Dryden Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory 10-10-2012 Baltimore, MD Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna 23a. Left 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ END disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or se a consequence of, if any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 🗌 Yes 2 40 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Usefficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nursa Practicions to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nursa Practicions to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the cause (s) and manner stated to the (Check To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) EFFNSE HWY, ANNAPOLIS, MDZ1401 ENEVIEUE 31. Date filed (Month, Day, Year) 32. Radistrar's Signature State 2012 OCT 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lwood Scott 6:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9069 Chestertown Georgetain tent Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days (Month, Day, Year) 08/14/1929 Hours Min. Director 213-24-0554 83 MD Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Chestertown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er man "natural", or items 23a the Me To LExaminer must be Funeral 9069 Georgetown Road 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. <u></u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Construction Laborer 1 and 2 should be of Health and Mental His is marked or 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Scott Gustavia Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Doris O. Scott/Wife 9069 Georgetown, RD Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 a Department of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury U.M. Church 10/22/12 Chestertown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral 855 High ST Chestertown, MD 21620 23a. Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Home Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Right lung mess with plend Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Belateral ICA occhision Hypertersion Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 3 Drn 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ILLCulum, InD D21313 10/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington 32, Register Chestistown (MDZibZo

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ OCTOBER 4, 9:15 A M LILLIAN R. SMITH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours 01/16/1958 MARYLAND Director 219-76-3939 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Completed by Funeral Director must be notified 1 XYes 2 No KENT CHESTERTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 200 MORGNEC ROAD 21620 UNITED STATES Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: "natural", 3 Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever မ EVELYN GOODMAN HARRY A. SMITH, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau HARRY A. SMITH, JR./BROTHER P.O. BOX 479 ROCK HALL, MARYLAND 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛮 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 10/08/2012 CHESTERTOWN, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 21. Signature of Funeral Service Licensee 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ NEUMONIA disease or condition resulting in death) 100 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine YS PHAGIA physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ☐ Live Birth ∠ ☐ Feed oc...
☐ Pregnant at time of death signed by the atte Day Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MENTAL RETARDATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SEIZURE DISURDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page CENEBRAL PALSY ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury s after death. I Director: Aft 1 Tes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide pleted filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allow investigation, it may open and a second at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the within 2 To the

State Registrar

peer Koad OCT

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Constant .

D0041587

stortown MD 21620

10-4-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:45P M Karen Louise Stevars 2012 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 101 Charles Street - Apt. Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Hours **Director** 217-82-3101 49 1 M 2 X F Yrs August 7, 1963 Maryland Usual Residence of Decedent 28a-f show 10a State 10b. County 10c, City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 X No W. Virginia Martinsburg Berkeley 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? items 23a Funeral 14 Apollo Court 25405 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. o. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lowe's Companies Sales Associate Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Roger Hood King, Beverly Ellen Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Hill - Daughter 146 Buchannan Drive, Stevens City, Virginia 22655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 Depation 5 Other (Specify) Metropolitan Crematorium 10/17/12 Alexandria, Virginia any injury 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signat re of F neral Service Licensee novert 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (o consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE ase a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed' death? 1 🗌 Yes certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Daughters Other: 4 Nursing Home 5 Residence 6X Other Hospital 1 Yes 2 XNo ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 5 Pending iniury 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertliying Nurse Practitionar. To the best of my over one dath of the cause of and manner as stated (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 15, 2012

Registrar

Name and address of person who

00

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31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

in gistrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia Medic		T. Decedent's Name (Pirst, Middle	Marializ	Lop	ez Sa	avedra		Mo	te of Deatl onth ober	Day	2012	3. Time of 5:40	Death AM
	Examin		4a. Facility Name (if not institution Holy Cross Hos	n, give street and number)			4b. City, Town, or Silver	Sprir	of Death			ty of Death		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2		te of Birth	Vaarl	9. Birthp	lace (State or	r Foreign
	Director		Usual Residence of Decedent	1 □ M 2 😿 F	0	Yrs.	World Bays		22	'14/2(Mary1		
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	e Mary r 28a-1 notifie	Director	MD Prince	e Georges			Hyatts	SVIIIe	e 				1 🗆 Yes	2 No
	with th		7755 Emerson F	Road			10f. Zip Code	20784	/ ₁	1	0g. Citizen of	f What Count JSA	try?	
	items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S		Vas Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Specify Yes	s or No-	14. Ra	ace - America		
36	affer o	d by	1 🔀 Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 🗌 Yes 2 🕱 If Yes, Give	No		Yes 2 No					ack, White, e fy: Whit		
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Mar	2 shou h and 7 is m traum	18	19a. Informant's Name/Relations		. 1	T .	g Address (Street a				-		ode)	
re,	f and f f Healt item 2 other		Laura Saavedra 20a. Method of Disposition	MC	20b. Pl	lace of Dispos	Emerson Edition (Name of		Hyattsv Date		MD 2 20c. Location		vn, State	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign, lure of Fungral Service	Cole	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22	Name and Addres	ss of Facility	Cole Fu	ınera	1 Serv	rices,	P.A.	7.4410
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9289	rtificate ing phy e as th		IF FEMALE:								1			
Box 687	death certifica ie attending p ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	ey				ate of deliver	,	ear
P.O.	at the d by th detache		g ∐ Unknown Part II. Other significant condition		ut not resu	ulting in the u	nderlying cause giv	ren in Part I.	. 23	e Did toh	acco use con	atribute to the	cause of de	eath?
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l Re	Physician: The lav r this certificate has eral director, page 2		25. Was case referred to medical				00 8			perform Yes 2		death?	2 No	
Vita	ysicia is certi direct	To Be	examiner? 1 🗆 Yes 2 🕱 No	Hospital:	ent 2 🗆 E	ER/Outpatien	Othe	er: _	h (Check only or rsing Home 5		nce 6 \square Oth	her (Specify)		
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sior	il or Attending P s after death. I Director: After t d in by the funers	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	not be	ırv - At hor	me. farm. stre		Yes 2 🗆 1		cation (Stre	eet and Numb	her or Rural F	Poute Numbe	ar.
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L Medical E	Physician: To the best of examiner: On the basis of e Nurse Practitioner: To the	xamination	and/or investi	gation, in my opinio	n, death occ	curred at the time	e, date and	place, and du	ue to the caus	se(s) and man	ner stated.
	Vithii Comp		29b. Signature and title of certifier				29 c. License				d. Date signe			
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			30. Name and address of person Richard N. Foo					thesda	a, Mary	land	20814			
Į.	Stat	· 2	31. Date filed (Month, Day, Year)	32. Jegistra	ar's Signatu	A. So	a Ked					-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 12:20 AM 10 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** are + Rehab itizen's Frederick Frederick Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** (Month, Day, Year) 85 216-22-2068 Director 1**X** M 2 □ F March 31,1927 Maryland Usual Residence of Deced er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector 1 XYes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 1920 Rosemont Ave. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? X Yes 2 No 1945 -Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify White Completed 3 X Widowed 4 ☐ Divorced 1949 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working | Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with h and Mental Hygien 7 is marked other th Entertainment Industry 9 Tavern Owner injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Olive East Randy Shelhorse permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803 Stonehouse Court, Frederick, MD 21702 Barbara Monath / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 10/16/2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a Part 1 Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate terval Betweer Immediate Cause (Final t and Death Ph_sician/ disease or condition Medical resulting in death) or as a consequence Examiner sertionly list over the exif any, leading to immediate cause. Enter Underlying Examine (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed to (or as a opnsequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has autopsy perform certificate 2 🗌 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after deau... he Funeral Director: After th maletely filled in by the funera 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) かけ State Registrar

12-07676 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kevin Suskie State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day October 10, 2012 Medical Examine 1400 hrs Kevin Charles Suskie 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 615 Island Creek Court Annapolis Anne Arundel 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 219-31-3318 1 X M 2 F 21 02/11/1991 Country Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 Yes 2 No 28a-f show Annapolis Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

aut. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Modical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Island Creek Court 21401 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: 3 Widowed Divorced Give Yea Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Hall for 21215-0036 12 Sound Engineer Creative Arts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Suskie Linda S. Zido 19a. Informant's Name/Relationship (Type, Print) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Bernard Suskie - Father 526 Forest Hills Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Department o
Important:
injury or oth St. Mary's Cemetery 10/16/2012 Annapolis, MD Donation 5 Other Specify permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Asphyxia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Hanging Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been sign funeral director, page 2 should be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injun 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject found hanging 1 Natural FOUND: Pending 1 Yes 2 ✔ No the Oct 10, 2012 1350 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 615 Island Creek Court, Annapolis, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 11, 2012 Mela 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 2012 Registrar's Signatur State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

12-07688 Arpie E Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1714 hrs Arpie Elizabeth Smith **Medical Examiner** October 10, 2012 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Cheverly Prince George Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) NC Months Days Hours Min Director 578-18-9391 XX 12/18/1913 98 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2XX No Upper Marlboro Prince George's "natural", or items 23a or 28a-f show |Examiner must be notified at once. MD Imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: Viem 27 is anarked other than "natural", or items 23a or 28a-f sho or other tramanic event, the Medical Examiner must be notified at once. Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 14705 Willoughby Rd. 14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Marrier 1 Never Married 2 Yes XX No 3 XXVidowed Yes, Give Year 1 Yes 2 No specify: 4 Divorced White <u>≨</u> or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 6 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie Johnson Henry Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Crawford
20a. Method of Disposition Upper Marlboro, MD 20772 4705 Willoughby Rd. daughter 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, XXBurial 2 Cremation 3 Removal from State crematory or other place) 10/16/2012 Brentwood, MD Donation 5 Other Specify Lincoln Cemetery 22 Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral prvice Licensee Annapolis, MD 21401 12 Ridgely Ave. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Sa attending physician a AMENDED UNPENDED Physician/Medi 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day use as t Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed death? Yes 2 ✔ No 1 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: director å Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 No 5 Pending death. the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 24 hours after of Funeral Direc 3 Suicide Could not be . = determined 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 11, 2012 arrely Harrely 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

32. Redistrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mon 10/12/2012 Physician/ 2349 Olga Adelle Sweeney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Social Security Number 6 Sex 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 9/2/1927 1 ☐ M 23€3F Yrs. Director 85 218-20-0714 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes XX No Annapolis MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20711 USA 5606 Brookswoods Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Armed Forces?

1 Yes No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3XXWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 12 Clerical Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, and Mental H မ should be Olga Angeline Lowen Adam John Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Deale, MD 20751 Sandra Kent daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Donation 5 Other (Specify) Maryland Veterans Cem 10/23/2012 Cheltenham, MD Signature of Funeral Service 22. Name and Address of FacilityHardesty Funeral Home, P.A. Annapolis. MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the Ocath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ON Hospital: Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A' 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title and address of person who completed cause of death (Item 23a) (Type, Print) Judy Joseph Herbert, M.D. 31. Date filed (Month, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

	-	State	ate of Maryland		artment of H tificate of D			711	12 35476
		Registrar 1. Decedent's Name (First, Middle, Last)			inicate of E	,cuii	2. Date of Dea		3. Time of Death
Physicia Medic	al	Harry Israel					0ctobe	$r 1^{12}$, 20	
Examin	er	4a. Facility Name (if not institution, give street a Medstar Montgomery N		er	4b. City, Town, or 01 ney	Location of Death		4c. County	ntgomery
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
Director ≥		066-07-0873 1X□ M 2 Usual Residence of Decedent	96	Yrs.			May 4,	1916	New York
ıryland a-f sho iled at	Director	10a. State 10b. County	10c. City,	Town or Loc	r Spring				10d. Inside City Limits 1 Yes 2 X No
the Ma or 28a e notif		Maryland Montgomery 10e. Street and Number		31146	10f. Zip Code			10g. Citizen of	What Country?
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er dea or iter miner	by Fu	1 Never Married 2 X Married	as Decedent Ever in U.S. med Forces? ☐ Yes 2 ☐ No	11	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto		Blac	ce - American Indian, ck, White, etc.
ours aff	ted	3 U Widowed 4 U Divorced Ye	Yes, Give 42-14	' '	Yes 21 No				white
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be file lental F rked o lic eve	70 E	Nathan Stein					e Roths		e)
should and N is ma		19a. Informant's Name/Relationship (Type, Pri			g Address (Street a				
and 2 Health tem 27		Gayle Shackleford, [20a. Method of Disposition	20b. Pla	ace of Dispo	Artesian sition (Name of		Date		855 - City or Town, State
Page 1 nent of ant: If i		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Jude	metery, cren ean Me	morial Ga	rdens 10	/15/12	01ney	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of funeral Service icenses	MON	90 3 78	reninsky 4 Carroll	HEBYEW F	uneral	Home	DC 20012
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	ns that caused the death.						Approximate Interval Between
Physician/ Medical			HRONIC 6		WCTWE L	_ung D	USEAS:	E	Onset and Death
Examiner			Due to (or as a conseque	ence of):					
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ath certificate be execut attending physician and for use as the burial-iteal	n/Me		yes, outcome of pregnan					23d. Da	ate of delivery
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and company filled in by the funeral director, page 2 should be detached for use as the burial trans.	Physician/Me	in the past 12 months?	☐ Live Birth 2 ☐ Fetal☐ Pregnant at time of de☐ Unknown		Description of the Control of the Co	у			onth Day Year
requires that the death been signed by the attershould be detached for		9 ☐ Unknown Part II. Other significant conditions contribut	ting to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to the cause of death?
quires the sign of signs of the sign of the sign	ed by						1 🗆 '	Yes 2 No	3 Probably 4 K Unknown
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pital or Attending Physician: The law burs after death. eral Director: After this certificate has filled in by the funeral director, page 2		25. Was case referred to medical			26 Pla	ace of Death (Chec	1 🗌 Yes		1 Yes 2 No
Physician: The this certificate al director, pag	To Be	examiner? 1 Yes 2 No	al: 1 🔀 Inpatient 2 🗆 E	R/Outpatier	Othe	ir.	ome 5 Resid	lence 6 🗆 Oth	er (Specify)
ding PI h. After th funera	ate	1 Natural 5 Pending	a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1		28d. Describe h	ow injury occurr	red
Attender deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		103 2 2 110	28f. Location (S City or Tow		er or Rural Route Number,
pital or ours aft eral Dir filled in		29a. Certifier 1 Certifying Physician:		م طفع ما ما ما ما ما	say word at the time	data and place			ner en etated
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After common of the funeral Director After common of the funeral Director After common of the funeral Director After and the funeral Director After and Director After After After and Director After and Director After and Director A	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: 01 Certifying Nurse Practice (Check only one) 1 Certifying Nurse Practice (Check only one) 1 Certifying Nurse Practice (Check only one) 1 Certifying Nurse Practice (Check only one) 1 Certifying Nurse Practice (Check only one) 1 Certifying Physician: 02 Certi	the basis of examination	and/or invest	igation, in my opinio	n, death occurred a	it the time, date a	nd place, and du	e to the cause(s) and manner stated.
Within the control of		29b. Signature and title of certifier	0 .		29c. License	number		29d. Date signe	d (Month, Day, Year)
ISTI		30. Name and address of person who complete	ted cause of death (Item:	23a) (Type, F	rint)	1421		10/1	2/2012
		TIMOTHY O. ETHABOR,			Philip	Drive, O	lney, M	20832	2
Stat Registra		31. Date filed (Month, Day, Year) OCT 1 7 2012	32 Registrar's Signatu	ire dan	Med				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Dolores Smith 12:30 am October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10124 Pierce Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 579-48-8713 Director 1 □ M 2 🏝 F Yrs. March 1, 1932 Washington, DC I Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Evaminer must be nutified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10124 Pierce Drive 20901 USA within 72 hours efter deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. White Specify: þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Purchasing Assistant 27 is merked othe traumatic event, Be filed 17. Father's Name (First, Middle, Last) permit. Pege 1 end 2 should be fileo Depertment of Heelth end Mentel H, Important: If Item 27 Is merked oth any liuly or other traumatic even ance. 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Bernard Hynson Dorothy Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2932 Stonecreek Drive, Sandy Hook, VA 23153 Michael Smith/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oct. 17, 4 Donation 5 Other (Specify) of <u>Heaven Cemetery</u> Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the eeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myelogenous Leukemia disease or condition mos. Medical resulting in death) Examiner Myelodysplastic Syndrome 1 yr. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): oftending providential transit Exami pitel or Attending Physician: The lew requires that the deeth certificete be executed ours after death. erail Director: After this certificete has been signed by the ettending physicien end filled in by the funeral director, page 2 should be detached for use es the burial transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2X N 1 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 Yes 2 No Investigation
6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitel o within 24 hours af To the Funeral Di completely filled in Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) She D21910 October 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3921 Ferrara Drive, Silver Spring, MD 20906 Peter Sherer, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2012

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ 2012 $3:00pm^{M}$ Eleanor Blackburn Sisson October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Country Living For Seniors Poolesville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Months Director 577-28-3376 1 🗆 M 2 🕱 F Jan. 26, 1921|Pennsylvania 91 Usual Residence of Decedent or 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits at Director be notified 1 Yes 2 X No Poolesville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must ! 20837 United States 15201 Montevideo Road or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 9 Retail Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Katherine Washington Matthew Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20880$ 19a. Informant's Name/Relationship (Type, Print) item 27 (Daughter) 208 Washington Grove Lane, Washington Grove, MD Sharon G. Sisson or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 10/17/12 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Lig 26a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ molom Acute Myocardial Infarction resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) 180 a-transit Atrial Fibrillation that initiated events resulting in death) Last and Due to (or as a consequence of): 6 10 attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☒ No Day Pregnant at time of death Unknown the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 X Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) မ 27. Manner of Death 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After (Month, Day, Year) injury Natural 5 Pending UnKM trippe 1 Yes 2 No 2012 death 🔀 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number of Sural Floute Number of City or Town, State) 3 ∐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined R 5515TEU within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and vue to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vinu Ganti, M.D.

OCT 17 2012

31. Date filed (Month, Day, Year)

D41162

19529 Doctors Drive, Germantwon, MD 20874

October 15, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State		artment of Health and	Mental Hygi	ene 2012	35479					
			Registrar 1. Decedent's Name (First, Middle, Last)		tificate of Death	2. Date of Death	1	3. Time of Death					
. 16.	Physicia Medic	al		SCHWARTZ			14, 2012 ^{ar}	10:30 P M					
ز	Examin	er	4a. Facility Name (if not institution, give street and number) Brighton Gardens		4b. City, Town, or Location of Deat Columbia	th	4c. County of Death Howard						
	Funeral Director		074-24-3597 1□M2以F	ge (In yrs. last birthday) 80 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) Cour	place (State or Foreign htry) Oklyn, NY					
	show dat	for	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits					
	r 28a-f notifie	Director	MD Montgomery 10e. Street and Number	01 ney	10f. Zip Code			1 Yes 2 X No					
	s 23a o	Funeral	4229 Cherry Valley Dr.		20832		0g. Citizen of What Cou U.S.A.	ntry?					
920	e filed within 72 hours after death with the Manyland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Pes 2 X 1 Pes 2 X 1 Pes Give Year or Dates.	XVo.	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer ☐ Yes 2 【 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.					
15-0	72 hour "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation and of work done during most of wo	rking 1	16b. Kind of Business/In	dustry					
212	within 7 giene. er than , the M		Elementary/Secondary (0-12) College (1-4 or 12)	5+) Import	O NOT use retired) CET	I	morting						
land	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Harold Seerman		18. Mother's Na	me (First, Middle, Ma Rot	aiden Surname) Shbeind						
Mary	ge 1 and 2 should be file nt of Health and Mental I : If item 27 is marked o or other traumatic eve	3	19a. Informant's Name/Relationship (Type, Print) Judith Bass, daughter	19b. Mailin 4229 (g Address (Street and Number or Ru Cherry Valley Dr.	ural Route Number, C	City or Town, State, Zip of 20832	Code)					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once,		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Method (Specify)	- undean men	natory or other place) norial Garden Oct	:.17,2012	20c. Location - City or To						
Balti	permit. I Departm Importa any inju once,	- 3	21. Signature of Fureral e un licenson	22	Name and Address of Facility To	rchinsky	hebrew run	e ral Home 012					
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one gause on each lin	d the death. Do not ente	r the mode of dying, such as cardiac	c or respiratory arres	t,	Approximate Interval Between Onset and Death					
ا بيسا و	Medical		Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of):										
	Examiner	Ž.	Sequentially list conditions, b.										
	uted J gnsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
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3760	ficate be g physici as the b	/ledical	d										
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bytisizans:	Physician/Me		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year					
Division of Vital Records, P.O.	requires that the dea been signed by the a should be detached	by	Part II. Other significant conditions contributing to death I	out not resulting in the u	nderlying cause given in Part I.		acco use contribute to the						
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of V	g Phys er this neral di	te: To	27. Manner of Death 28a. Date of inju		t 3 □ DOA 4 □ Nursing I 28c. Injury at	Home 5 Residen 28d. Describe how	nce 6 X Other (S <i>pecif</i> y v injury occurred	Living					
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	To the Hospital or within 24 hours afte To the Funeral Dir	Medical	29a. Certifier 1 K Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of an only one) 3 Certifying Nurse Practitioner: To the	igation, in my opinion, death occurred death occurred at the time, date and	at the time, date and	place, and due to the ca	use(s) and manner stated.						
29b. Signature and title of certifier D56531 29d. Date Oct.								Day, Year) 2					
_			30. Name and address of person who completed cause of a Henry Li, MD 8600 Snowden I	River Parkwa	ay #301, Columbia	a, MD 2104	45						
	Stat Registra		31. Date filed (Month, Day, Year) OCT 17 2012	rar's Signature									

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iner	4a. Facility Name (i					NTER	4b. City	FOR	r Location				4c. Coun	nty of Death	
ľ	5. Social Security N 215-82-	-0772	6. Sex	2 X F	7. Age (In yrs. 90	last birthday) Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date of (Month, 3 / 1 9	Birth Day, Yea	22		hplace (State or For Intry) NC
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Dire	10e. Street and Nu							ip Code				10g.	Citizen o	of What Cou	
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State Registrar

DAVID DUNN - 6
31. Date filed (Month, Day, Year)

NOV 0 5 2012 DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

032275

BEL AIR, MD.

21014

adder 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	Maryland		artment of I tificate of L	Health and I			012	35481
		Registrar 1. Decedent's Name (First, Middl)	e, Last)		061	incate or i	Jean	2. Date of Dea	Reg. No.		3. Time of Death
Physici Medi		MARY JANE THOM	(PSON					OCTOBE	Day	2012	12:05 A M
Exami		4a. Facility Name (if not institution		er)		4b. City, Town, o	r Location of Death			unty of Death	12.03 11
	,	ANNE ARUNDEL MI				ANNAPOLI				NE ARUN	
Funeral Director		5. Social Security Number 214-52-2490	6. Sex 7	Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		9. Birth	place (State or Foreign try)
	1	Usual Residence of Decedent		6	4 Yrs.			07/04/	1948	NEW	JERSEY
yland •f sho	tol	10a. State 10b. County		10c. City, *	Town or Loc	cation				1	0d. Inside City Limits
e Mar r 28a notifii	Director	MD KENT 10e. Street and Number		ROCK	HALL	T					1 X Yes 2 □ No
/ith th	la l					10f. Zip Code		1.	Ü	of What Cour	,
eath v	Funeral	21630 HILL LAND	12. Was Deceder	.O. BOX nt Ever in U.S.		21661 Vas Decedent of H	ispanic Origin? (Sp			STATE Race - Americ	
fter de mine	by	1 Never Married 2 XMar		s? X No	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White,	
OOS ours a tural'	Completed	3 Widowed 4 Divorced	real of Dates	s		Yes 2 XNo	Specify:		Spe	wHI	TE
15- 72 hc n "na Aedic	lg l	(Specify only high	nt's Education est grade completed)		(Give k	ent's Usual Occup iind of work done o ONOT use retired)	ation during most of worl	king	16b. Kind a	of Business/Inc	dustry
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at		Elementary/Secondary (0-12)	College (1-4 c		BEAUT	,			ETOLOGY		
filed all Hy doth	Be	17. Father's Name (First, Middle, I	ast)				18. Mother's Nan	ne (First, Middle, i			
Iryland 2. Suld be filed with a Mental Hygie marked other matic event, the	욘	WILLIAM T. HUDS	ON				ANNIE RE				
ore, Maryland 1 and 2 should be filed of Health and Mental Hy iften 27 is marked oth other traumatic event		19a. Informant's Name/Relations	_		19b. Mailin	g Address (Street a	and Number or Rui	ral Route Number	City or Tow	ın, State, Zip C	Code)
		CARROLL THOMPSO 20a. Method of Disposition	ON / HUSBANI	<u> </u>	21630	HTLL LAI	NE ROCK E	IALL, MA	RYLAND	21661	
		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 Removal from Sta	ate cem	netery, crem	atory or other plac	· i			ion - City or To	,
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service I		CHES							, MARYLAND
a a E e c		Kuk & 9	felfante	ein	[FE]	LLOWS, HI O SPEER I	ELFENBETN ROAD CHES	TERTOWN	AM FUN , MARY	IERAL H LAND 2	OME, P.A. 1620
	П	23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause on each	sed the death. [line.							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	0	ast C	494	1					Onset and Death
Medical Examiner		resulting in death)	Due to (or a	as a consequen	ice of):						
BILL ST	ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequen	ce of:						
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury									
exect an an	Ë	that initiated events resulting in death) Last	Due to (or a	as a consequen	ce of):				_		
DIVISION OF VICES THE HOSPITAL OF Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the Vices of the Control o	dical		d						.		
oo/ certifica nding p	/We	IF FEMALE:	23c If was outcorn	ne of pregnancy	,						7.01845 - Y
ords, P.O. BOX 08/ requires that the death certificate been signed by the attending poshould be detached for use as it	Physician/M	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal d t at time of dea	eath 3 🔲	Ectopic pregnanc Other (specify)	у			Date of delive	ry Day Year
the de ached	hysi	1 Yes 2-No 9 Unknown	9 🗆 Unknowi		0 🗀	Other (specify)			_		
that the	by P	Part II. Other significant condition	ns contributing to death	n but not resulti	ng in the un	nderlying cause giv	en in Part I.	23e. Did tol	bacco use c	ontribute to th	e cause of death?
dS, quires en sig ould b								1 □ Y	es 2 🗆 N	o 3 🗆 Prob	ably 4 Unknown
VICAL MECONGS, ysician: The law requires s certificate has been sig director, page 2 should b	Completed							24a. Was a			sy findings available
The : The cate h	Con							_ perfor		death? 1 🔲 Yes	
icectol	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Chec	k only one)			
Physer this eral d	e: 10	27. Manner of Death	28a. Date of in		Outpatient b. Time of	3 DOA 28c. Injury	4 U Nursing Ho	ome 5 Reside			
arth. r: Afte	icat	1 Natural 5 Pendin 2 Accident Investig	gation	Day, Year)	injury	work'		Zod. Besonbe ne	w injury occ	unca	
VISION OI or Attending Pl fter death. irector: After th n by the funera	Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of Ir	njury - At home etc. (Specify)	, farm, stree	et, factory, office		28f. Location (St		mber or Rural	Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	a C	X						City or Towr			
Hosp 24 ho Fune	Medical	(Check \ 2 ∟ Medical E	Physician: To the best of xaminer: On the basis of	f examination ar	nd/or investig	gation, in my opinio	n, death occurred a	t the time, date an	d place, and	due to the cau	se(s) and manner stated.
Fo the within Fo the complex	Σ	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practitioner: To	the best of my k	(nowledge, c	death occurred at the 29c. License				nd manner as st gned (Month, D	
		(M)				D 69	5272		10/11	3	····
15			who completed cause of	death (Item 23	a) (Type, Pri	int)	(.				A A
TH		21 Data filed (Month Day Mary)	Jey 200		edic.	1 Sland	1704	< 210	1700	V. brira	MO 2140
Sta Registra	_	31. Date filed (Month, Do Men)	32. Regis	rar's Signature	1. 1	St. St. March					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 20b & 20c, 10/12/12, RM State of Maryland / Department of Health and Mental Hygiene Amend #9 per FH G933 11/9/12 dk

- State Registrar

- Reg. No. 35482 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 8, 2012 1:49 PM CHARLES DIETZ THEOBALD, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT ROCK HALL 4902 CROSBY ROAD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 **X** M 2 □ F Davs Hours Min 02/09/1919 PA 93Yrs **Director** 164-10-5312 Usual Residence of Deceden 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4902 CROSBY ROAD 21661 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced NAVY 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 CONSTRUCTION OPERATING ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ FREDERICK THEOBALD MARTHA CUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES D. THEOBALD, JR. SON 255 ST. CLAIR DRIVE MT. LAUREL, NEW JERSEY 08054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
illadelphia Crematory 10/16/2012 STEVENSVILLE; MARYLAND 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Artero Sclevatic Condia Vascular Dispase Onset and Death Ph_sician/ 12 Wars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Din Type 2; ACHOI; HTW; 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 X 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2-X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: At bleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0050996 10/9/2012 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Chastortown MD Staddard MD Veil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/20/2012 PAUL PARKER TETER 2025 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Garrett 0akland If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last hirthday 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Days Min. 82 234-44-2905 Director 1 ፟ M 2 □ F WV 09/24/1930 Usual Residence of Decede 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Preston Aurora 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 26705 PO Box 75 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 K Yes 2 No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1951-53 Specify: White 1 ☐ Yes 2 1 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Oil Company 8th Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floda Rowan Elza Teter and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve once. ٩ Clem Andrew Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 75, Aurora, WV 26705 Janet C. Teter/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2012 Aurora, WV Aurora Cemetery Signature Funeral Privice Licencee 22. Name and Address of Facility
Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Pneumonia days Medical resulting in death) Due to (or as a consequence of): Examiner vears Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed in funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 2 XNo 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, မြ npatient 2 ER/Outpatient 3 DOA 27. Manner of De Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicart Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Marse Pyretitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) and address of be Goralski, M.D. 311 N. Fourth St., Oakland, MD 21550 Robers -- 31. Date filed (Month, Day, Year) Robert A.

DHMH 17 Rev 06-2011

State Registrar

12-07939 Dennis Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 35484

		1- For State Registrar		Certific	ate of	Death			Re	g. No.	2 1 6	_ 0040
Physic		Decedent's Name (First, Midd)	e,Last)						Date of Death Month	Day Yea	,	3. Time of Death
dedical Exam	iner	Delilian Revall						C	ctober 19	<u>), 2012</u>		1802 hrs
		4a Facility Name (if not institutio	n, give street and number) h Road		41	p. City, Town, or Frederick	Location of	f Death		4c. County of Frederical		
Funera		5. Social Security Number	6. Sex 7. Age	e (In yrs. last bii	thday)	If Under 1 Yea		1		n(MM/DD/YYYY	9. Birt Foreig	
Directo		217-56-2383	1 M 2 F	52	Yrs.	Months Day	s Hours	Min.	08/31/	1960	Cou	untry) MD
any		Usual Residence of Decedent 10a, State 10b, County		10c, City, Town	or Locatio	in .						10d. Inside City Limits
E			ederick		deric							1 Yes 2 X No
faryland 28a-f show	ţċ	10e, Street and Number	delick	rie	T	10f. Zip Code			140	g. Citizen of Wh	-1.0	
th the Maryland 23a or 28a-f sho notified at once.	Director	8000 Edgewood	Church Post	4		2170	2			United		•
ith the 23a		11. Marital Status	12. Was Decedent		T 13 M/as	Decedent of His		in2 / Specif				can Indian, Black,
death w or items must be	uneral		arried Armed Forces?		If Ye	s, specify Cubar	n, Mexican,	Puerto Rica	an, etc.)	White		Jan Inglan, Diack,
fter de	1 1	3 Widowed 4 X Div	orced If Yes, Give Year	X No	1 1	Yes 2 [™] No	specify:			Specify:	Whi	te
ours a atura camin	d by	15. Decedent's Education (Spec	or Dates: cify only highest grade com	pleted) 16a.		s Usual Occupa			done	16b. Kind of Bus	iness/Ir	ndustry
6 - 72 h	leted	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life				7.1		-
0036 within iene. rer tha	Comple		2	P	narma	cy Techi				Pharmac	euti	cal
filed Hyg	ပို	17. Father's Name (First, Middle, Clarence L.						s Name (Fir ne E.		aiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	19a. Informarit's Name/Relations		T 19	b. Mailing	Address (Stree				per, City or Town	State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once	-	Clarence Taylor		- 4								D 21788
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service	Licensee		_		-			neral H		
ERAS O		104 E. Main St., Thurmont, MD 21788										
Physician 'M		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									rt	Approximate Interval Between Onset and
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			b.	querica or).								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):								
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760, Teate be physical the bunt	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnancy		- [7			23d. Date of c	lelivery	
		past 12 months?	1 Live birth 4 Pregnant at t			I death 3 [Ectopic	pregnancy		Month	D	ay Year
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ding Pl	Ë	27. Manner of Death 1 X Natural 5 Pendi	28a. Date of Injur (Month, Day,Ye	y 28b. ear)	Time of Inju		ry at Work? ′es 2 ☐ 1		. Describe ho	w injury occurre	d	
isio	cati	Felial	tigation 28e. Place of Inju	At home for	arm etrant				Location (St	root and Number	or Dur	al Route Number, City
Division of Vital Records, pital or Attending Physician: The law require and after death. eral Director. After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	deter	not be (Specify)	ury - At nome, n	ariii, su eet,	ractory, office b	ullullig, etc.	201.	or Town, Sta		OI Ruis	ar Route Number, City
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s								s stated	d.			
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state the time, date and place, and due to the cause(s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as state the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time, date are the time,												
29b. Signature and title of certifier							e number			29d. Date signed	(Mont	th, Day, Year)
		his l	O.C.M.E. October 20, 2012						2012			
		30. Name and address of person v			- låi	Chro - A. D - III		ID 04000				
	tota	Ling Li, MD Assistar 31. Date filed (Month, Day, Year)	nt Medical Examiner 32. Registrar		-		imore, M	ID 21223	· 			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 14, 2012 Year 3:55 AM Trapaso Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northampton Manor Care & Rehab Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min (Month, Day, Year) 198-18-6280 87 Director 1 ☎ M 2 🗆 F Sept. 5, 1925 Pennsylvania Usual Residence of Decede 28a-f shov 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c City Town or Location Director Frederick 1 X Yes 2 No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 200 East 16th Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White 3

Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Gas Station Business Owner should be filed with and Mental Hygien 7 is marked other th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) ဂ Nicholas Trapaso Marv 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1534 Beverly Ct., Frederick, MD 21701 Anthony Trapaso, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any injury or other Oct. 2012 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 21. Signature Resthavenes Fufferal Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the dise shock, or heart failure se, or complications that caused the death. Do not enter List only one cause on each line. Immediate Cause (Final disease or indition resulting in death) BRIVE Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Exami that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending plant lifer use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospita Other: 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manne of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t A hours after de...

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in by the fur **V**Natural 5 Pending injury work? 1 🔲 Yes 2 No Accident Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) prtifying Nurse Practitioner: To the best of my knowledge, death curred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) iled (Month, Day, Year. Registrar's Signature State OCT Registrar

DHMH 17 Rev 06-2011

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANCINE O Choben 10AM HOMPSON 10 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENERAL HOSPING HOWARD COUNTY COLUMBIA Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 256-56-3064 75 Director 1 ☐ M 2 🖾¥ 9/12/1937 GA Usual Residence of Decedent r than "netural", or items 23a or 28e-f show the Medical Expringer must be notified at filed within 72 hours efter death with the Maryland al Hygiene. 5 other than "netural", or items 23a or 28e-f shov 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Hanover 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21076 USA 1462 Fairbanks Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: **Black** Completed 3 X Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Child Development Specialist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked ott eny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Jewel Wallace Nathaniel Kellogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlena Tyrell daughter 6332 Burnt Mountain Path Columbia, MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State 10/24/12 4 Donation 5 Other (Specify) Arlington, VA Arlington National Cem Signature of Funeral Septe Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner orm dum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Systemic that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 1 Yes 2 9 Unknown Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination ana/or investigation, in the properties of the cause (s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 030641 new O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Never neck Road Essex 201-109 Sabapalm amesh egistrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\frac{\text{Month}}{10}/10/201$ Thomas Teutsch, Sr. 4:08 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 800 Carson Avenue Oxon Hill Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Hours 460-24-1589 **Director** 1 X M 2 🗆 F 07/10/1923 Texas 89 ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Oxon Hill 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20745 800 Carson Avenue iral", or items? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. þ 1 Never Married 2X Married 2 No WWII 1 Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Plumbing Inspector D.C. Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ 0'Levv Force Н. Teutsch Marvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Wife Monica M. Teutsch 800 Carson Ave., Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 10/23/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lice 22. Name and Address of Facili George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 CC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cape on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ō in the past 12 months? Month Pregnant at time of death Dav Year 2 🗆 No the detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 KN the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after ucco...

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X X latural 5 Pending work' 1 Tes ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my linewledge doeth consered at the time, date and place, and due to the 29b. Signature and title

State Registrar LINE CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 100712/2012 Tekle Berhane Tamanu 8:15 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) 01/01/1950 Eritrea 534-19-3541 62 Director 1 X M 2 □ F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han matrical and injury or other traumatic event, the Medical Examinar must han matrical and injury or other traumatic event, the Medical Examinar must han matrical and injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park MD Montgomery 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20912 6700 Conway Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Tsehitu Teklu ပ္ Berhane Tamanu 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00~Conway~Ave., Takoma Park, MD 20912Sarah Berhane-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven 10/18/12 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility W.H. Bacon Funeral Home 21. Signature of Funeral Service Licensee Wanda C. Bacon CC0361 3447 14th Street, NW Washington, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Un Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to innectate cause. Enter Underlying Cause (Disease or injury Due to for as a gonsecuence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriation that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 12 2 1 No 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completely filled in by the f 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-12-12 MO

Registrar
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32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 4, 2012 5:10 A EDWARD WARD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death CHESTERTOWN KENT CHESTERTOWN NURSING & REHABILITATION If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1**x** M 2 □ F MAYnth Day, 1949 **MARYLAND** 63 216-46-0591 Director Usual Residence of Decedent 28a-f show ä 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director must be notified 1 Yes 2 XNo QUEEN ANNE OUEEN ANNE'S MARYLAND o 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral USA 1020 DAMSONTOWN ROAD 21657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. Specify: WHITE "natural", 3 Widowed 4 XDivorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic manner. life. DO NOT use retired) Elementary/Seconday (0-12) HUNTING/OUTDOOR HUNTING GUIDE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ NELL H. (UNKNOWN) WOODROW H. WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 COTTONWOOD DR. GLEN BURNIE, MARYLAND 21061 CHARLES DUNCAN / FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, OCT. 5, 2012 STEVENSVILLE, MD CHESAPEAKE CENTER 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen-22. Name and Address of Facility
FELLOWS HELFENBEIN NEWNAM FUNERAL HOME PA
130 SPEER ROAD CHESTERTOWN, MD 21620 Part 1. Enter the disease, or compshock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. ter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown as been signed by the 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' 1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate 1 Natural 5 Pending work' thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fur 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 226000 CM D

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State

restertown, MD 21620

who completed cause of death (Item 23a) (Type, Print)

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Discortin		Registrar 1. Decedent's Name (First, Middle,Last)	Cei	rtificate of De	eam		Re 2. Date of Deat	g. No.	3. Time of Death
Physic edical Exam		J. WILLIS WELLS					Month October 7,		1921 hrs
		4a. Facility Name (if not institution, give street and University Hospital	number)		ity, Town, o altimore	r Location of Dea	th	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 213–16–7706 1 M 2	7. Age (In yrs. I		Under 1 Yea		_	6 (MM/DD/YYYY) 9. Bird 5, 1914 Foreig	
b		Usual Residence of Decedent		Town or Location			Бере.	3, 1314 30	
Maryland 28a-f show any d at once,	<u> </u>	10a, State 10b. County MD Kent		hestertow	n				10d. Inside City Limits 1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 501 E. Campus Ave. A	pt. 146		Zip Code 21620		10	og. Citizen of What Cour	ntry?
th with the ems 23a to be noti	uneral [11. Marital Status 12. Was I	Decedent Ever in U. Forces?	S. 13. Was Dec	cedent of Hi		Specify Yes or No- to Rican, etc.)		can Indian, Black,
after dea al", or it iner muy	by Fur	3 Widowed 4 Divorced If Yes, Give or Dates:	/ ear	1 Yes	2[X] No	specify:		Specify: W	hite
hours natur Sxami	ed k	15. Decedent's Education (Specify only highest g		16a, Decedent's Us	ual Occupa working life	ation (Give kind of e. DO NOT use re	work done	16b. Kind of Business/I	ndustry
9, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. item 27 is marked other than "natural", traumatic event, the Medical Examine:	Completed		2 (1-4 or 5+)			al Direc		Funeral H	ome
15-0 filed w Hygie d othe	CO	17. Father's Name (First, Middle, Last) William Howard Wells					ne (First, Middle, M		
212 ild be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Add	ress (Stree		. Farlow	ber, City or Town, State	Zip Code)
MD 12 shot th and 127 is umatic	_		daughter)				e, MD. 2		
Fe, s 1 and of Heal of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Remova	20b. F	Place of Disposition (crematory or other place). Paul's	Name of ce ace)	emetery,	Date	20c. Location - City or	,
Limo Page ment c		4 Donation 5 Other Specify:	St				0/12/12	Chesterto	wn, MD.
Baltin permit. P Departme Importan		21. Signature of Funeral Service Linensee	M0051	0 Gale	na Fui West (Cross St	. Galen	ephen L. Sc	haech 5
Physician /Medical		23a. Part I. Enter the disease, or complications that ailure. List only one cause on each line. Immediate Cause (Final disease a Head Inju		Do not enter the mo	de of dying	, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or a	s a consequence of	·):	•				
	niner	if any, leading to immediate cause. Enter Underlying Cause	s a consequence of	·):					
cecuted n and - transit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or a d.	s a consequence of):					
ਤਿਲ ਫ	edical	UNPENDED AMENDE							
Box 68760, e death certificate be the attending physici ed for use as the buri	ā	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregre birth	2 Fetal dea	ath 3	Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year
Box e death c the atten	Physici	1 Yes 2 No 9 Unknown 9 Unknown	gnant at time of dea known	J Other (
ires that the signed by I be detach	ā	Part II. Other significant conditions contributing	to death but not re	esulting in the underly	ying cause (given in Part I.		pacco use contribute to t	
of Vital Records, ng Physician: The law require the take this certificate has been simeral director, page 2 should b	Completed						24a. Was a autops	y prior to co	opsy findings available ompletion of cause of
ital Rec ician: The la certificate h	S						perform 1 Yes 2		3 2 No
/ital sician: is certi: lirector	B	25. Was case referred to medical examiner? Hospital: 1	Inpatient 2	ER/Outpatient 3	26.Place	Other Nursi		Residence 6 Other:	
n of Vil ding Physic After this funeral dire	일	27. Manner of Death 28a. Da	te of Injury	28b. Time of Injury 0000 hrs	28c. Inju	ry at Work?	28d. Describe h	ow injury occurred	· .
Division tal or Attendir s after death. al Director: A led in by the fu	Catic	2 Accident Investigation 28e. Pl		me, farm, street, fact		Yes 2 ✓ No ouilding, etc.		treet and Number or Rur	al Route Number, City
a partie 7 nontroe 7 nontr								ate)	
To the Ho within 24 To the Fu completely	29a. Certifier (Check only one) 2								
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day								
12		いつし、			O.C.	M.E.		October 12, 2012	
Rm		 Name and address of person who completed care Donna M. Vincenti, MD Assistant 	use of death (Item Medical Exam		Baltimore	Street, Balti	more, MD 212	223	
St Regis	ate trar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Registrar's Signatu	re	b				

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State Of Maryland A 1- For State Registrar	Certificate of L	Health and Mental H _i Death	ygierie Reg. N	2012 35492		
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Nico Aaron Wallace			Date of Death Month Day October 16, 2	3. Time of Death		
	4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital		o. City, Town, or Location of Death		4c. County of Death Prince George's		
Funeral		e (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth(MI	M/DD/YYYY) 9. Birthplace (State or		
Director	None 11 1 2 F	O _{Yrs.}	Months Days Hours Min.	Sept 14	4 2012 Foreign Country) MD		
any .	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	n		10d. Inside City Limits		
	MD Montgomery	Silver S	- 0	l in a	1 Yes 2 No		
the Maryland a or 28a-f sho tiffied at once	10e. Street and Number 13802 Castle Blvd. #T2		10f. Zip Code 20904	10g. C	10g. Citizen of What Country? USA		
s after death with the Maryland ran", or items 23a or 28a-f sho niner must be notified at once by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No	Decedent of Hispanic Origin? (Sps. specify Cuban, Mexican, Puerto et a. 2 No specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
2 hour "natu	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	during mos	Usual Occupation (Give kind of w tt of working life. DO NOT use retin		N/A		
21215-0036 total be filed within 7 d Mental Hygiene. Is marked other than its event, the Medical TO Be Comple	17. Father's Name (First, Middle, Last) Unavailable 19a. Informant's Name/Relationship (Type, Print) - mot	hor 19b. Mailing A			na Wallace		
MD and 2 shot aith and 1 is marking a numaric	Michelle Christina Wallace	13802	Castle Blvd: Si	lver Sprim	ng. MD 20904		
Baltimore, MC permit Pages I and 2 si Department of Health at Important: If item 27 injury or other frauma	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:		on (Name of cemetery, r place) O aven Cemetery	ct. 25,	Silver Spring, MD		
Balti permit. Departm Imports injury o	21. Signature of Funeral Service Licensee	22. Nar	me and Address of Facility Col	e Funeral	Services, P.A.		
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such as cardiac or respiratory arrest, shock, or heart							
/Medical	Death						
ae T	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):					
O, be executed sician and urial - transit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
b0, te be executed ysician and burial - transit	X UNPENDED AMENDED 23a	,27,28a-f,pei	me,g935 1-14-1	3 sm			
876 tificate ng phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at 0 9 Unknown	2 Fetal	death 3 Ectopic pregnat		3d. Date of delivery Month Day Year		
S, P.O. Box 6 irres that the death cer a signed by the attendi d be detached for use deby by a signed by by a signed d by Physicie	Part II. Other significant conditions contributing to death	but not resulting in the unc	derlying cause given in Part I.	1 Yes 2	o use contribute to the cause of death? No 3 Probably 4 ✔ Unknown		
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be priffication: To Be Completed				24a, Was an autopsy performed? 1 ✔ Yes 2			
Vital I hysiciau: this certifi I director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 🗹 ER/Outpatient 3	26.Place of Death (Check of B DOA Other Nursing	nly one) Home 5 Resid	dence 6 Other:		
ion of tending Pheath. tor: After the funeral	27. Manner of Death 28a. Date of Injur (Month, Day,Ye	28b. Time of Inju 5–12 fd 0618 l	1 Ves 2 X No. 1	28d. Describe how in	njury occurred		
after i Direction	3 Suicide 6 X Could not be determined (Specify)	ury - At home, farm, street, Residence	factory, office building, etc.	28f. Location (Street or Town, State) Silver Sp	and Number or Rural Route Number, City 13802 Castle Blvd.		
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam						
To To com	and manner stated. 29b. Signature and title of certifier	< 100	29c. License number O.C.M.E.		Date signed (Month, Day, Year)		
	30. Name and address of person who completed cause of de Russell Alexander MD. Assistant Medica		/. Baltimore Street, Baltim	ore MD 21223			
State	31. Date filed (Month CT 25 2012 32. Segistrar		. Lateriore Greet, Baitin	, <u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Thelma M. White 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab And Nursing Center Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 6. Sex 8. Date of Birth **Funeral** Days 1 M 2 F (Month P3/1918 94 Director 579-32-9209 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD Montgomery Olney 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4408 Thornhurst Drive 20832 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Virgil T. Steyer Nellie P. Grim 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Van Slycke / Daughter 4408 Thornhurst Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10/27/2012 Oakland, MD White Church Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ERDTIC CARDIO VACCUI Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Records, P.O. Box 68760 detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown the g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an Jas autopsy certificate | ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at the Hospital or Attending 1 Natural 5 Pending work? 2 No 2 Accident 3 Suicide 4 Homicide Accident Investigation To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Hursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) 20 9 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 ORIGINAL

3. Time of Death

7:30

Birthplace (State or Foreign Country)

MD

USA

White

10d. Inside City Limits

Onset and Death

MONSITI

1 X Yes 2 No

P M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35494 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Montri 10 20 12 Phyllis I. Wajbel 7:10 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 1 Year If Under 24 Hrs. . Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours Min. Director 218-26-8635 1 M 2 X F 82 4-26-1930 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Anne Arundel Annapolis MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1055 Little Magothy View 21409 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☑ No Specify: 3
Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within, 72 ment of Health and Mental Hygiene, tant: If item 27 is marked other than 'lury or other traumatic event, <u>the Me</u>lury or Elementary/Secondary (0-12) 12 College (1-4 or 5+) **Home** Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Orville Brown Marie McQuaid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Brightwell/ Daughter Annapolis, MD 21409 1145 River Bay Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) permit, Page Department of Important: If any Injury or once, 4 Donation 5 Other (Specify) 10-15-2012 Holy Cross Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Congestive taimie HEART Medical resulting in death) Due to (or as a consequent of): Examiner CONDIONASCULAR DISPOSE ATHE OSCIETOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months?

1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death, eral Director. After this certificate I filled in by the funeral director, pag perform 2 🗌 No 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ent D23743 OCx 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1852 pregunary CL De Peterpet MD 5020 MESS 4153AM 31. Date filed (Month, egistrar's Signatur 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35495 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ 9:30a M 2012 Carol A. Walker Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oueen Anne's 305 Love Point Ave. Stevensville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 260-72-9878 1 □ M 2 🕱 F 67 9-16-1945 GA Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Maryland Ħ 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 X Yes 2 ☐ No Oueen Anne's Stevensville MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a filed within 72 hours after death with Examiner must USA 305 Love Point Ave. 21666 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Black, White, etc. Armed Force or i Ş 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fred Thomas Jr. Lucia Doster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Love Point Ave. Stevensville, MD 21666 Jim Walker / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-12-2012 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MOC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it are secured to cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of a the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has performed? Yes 2 No 1 ☐ Yes 2 🗷 No funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury Natural 5 Pending Accident Suicide Investigation filled in by the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours a Medical 1-🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Rurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

3

T5 2012

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY October 21 ALTCE WILLIAMS 28AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore 4c. County of Death altimore BALTIMORE DIMAI کر Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of 9. Birthplace (State or Foreign Min. 227-46-0008 75 Hours Day, Year) Director 1 □ M 2 🗗 F AUG. 4, 1937 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits VIRGINIA LANCASTER KILMARNOCK 1X Yes 2 No Mary alice 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104A ABBY WAY 22482 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify:BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Known as: HOUSEKEEPER DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM WILLIAMS LEONIA CONLEY permit. Faga 1 and 2 st.
Department of Health an Important: If item 27 is n. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *LINDA LEE WILLIAMS (NIECE)* 521 SOUTH PORT LANE KILMARNOCK, VA 22482 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place MORNING STAR BAP. CH. CEM. 10/26/2012 HEATHSVILLE, VA Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY WADDY 6784 MARY BALL ROAD; LANCASTER, VA 22503 23a. Part 1. Enter the disease, or complications that caused the shock, or heart fillure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Fin Physician/ Cardiovasu Onset and Death rosc disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Due to (or as a consequence of): Examin To the Hoapital or Attending Phyalclan: The law requires that tha death cartificata ba axacutad within 24 hours aftar death.

To the Funeral Diractor: Aftar this certificate has baan signed by tha attanding physician and complately filled in by tha funeral director, page 2 should be datachad for usa as tha burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 2 100 1 Inpatient 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident work? 5 Pending injury Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ature and title of certifier 29c. License number mi M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Relvedere Ave, Baltimore MD221 MI ason onya Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2012 A M 3:30 JOAN D. YEIGH Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 317 COLUMBIA LANE STEVENSVILLE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) Director 173-30-0084 1 □ M 2 🗶 F 77 JAN. 18. 1935 PENNSYLVANIA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 Yes 2X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e, Street and Number 10g. Citizen of What Country? Funeral 21666 317 COLUMBIA LANE UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SECRETARY EDUCATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ CONYERS DAVIS MARY SCHONDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN H. YEIGH/HUSBAND 317 COLUMBIA LANE, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ${ \begin{smallmatrix} \text{OCT.} \\ \text{2012} \end{smallmatrix} }$ CHESAPEARE CREMATION CENTER 13, 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final endometrial COINCEN Physician/ YEAVS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off and Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancer 1 Yes 2 No 3 Probably 4 Unknown UNG Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has performed? 1 🗌 Yes 2 No Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 10/12/ 2012 oully, U.V

Registrar DHMH 17 Rev 06-2011

State

10

Pavilway

Annapolis, Md.

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

S. Selouich, MD

OCT

15

31. Date filed (Month, Day, Year)

2003 Medical

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35498 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cobev Yutzv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Cumber Land 4c. County of Death Western MD Regional Medical Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 220-30-8611 (Month, Day, Year) 11-01-1931 Director 1 M 2 □ F Maryland Usual Residence of Dec 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director be notified 28a-f 1 🗆 Yes 2 No MD Allegany Frostburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be 21532 10418 Borden Rd NW 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1954 1 Yes 2 No Specify. 3 Divorced 4 Divorced Specify: White Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Laborer Sand Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emma Baker Yutzy ပ Elmer Yutzy Health and Ment tem 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10418 Borden Rd NW Frostburg, MD 21532 Minnie Yutzy 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ott 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 10-23-2012 Cumberland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. Han MO0547 - Towers 60 W. Main St., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Immediate Cause (Final Physician/ WIRACENEBRAL disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to infinediate cause. Enter Underlying VASLULAN DISENSE Cause (Disease or injury that initiated events resulting in death) Last burial-tran aftending physician I for use as the buris Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?

1 Yes 2 No
9 Unknown detached Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 1 Yes 2 No 3 Probably 4 Unknown VASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 25. Was case referred to madical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) ျ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011 NOV 0 5 2012

nd address of person who completed cause of death (Item 23a) (Type, Print)

MD

Signa

Willowbrook Rd Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER I 2012 12:06 P M AARON EILEEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 100 OLD PLANTATION WAY BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country) 214-30-6167 Director 1 □ M 2 🛣 F 10/16/1930 MD 82 show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director must be notified 1 ☐ Yes 2 💢 No 28a-f MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number Funeral 23a 21208 USA 100 OLD PLANTATION WAY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or i any injury or other traumatic event than "hatural", or in þ 1 Never Married 2X Married 1 Yes 22 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SAMUELS LEON ZALIS LENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 ST. THOMAS LANE, OWINGS MILLS, MD JONATHAN AARON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 11/04/2012 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) f Funeral Service Linens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only or Interval Between Onset and Death Immediate Cause (Final disease or condition Lunc 'm cer Physician. 2 years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ⊆ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one 29b. Signature and title

Registrar DHMH 17 Rev 06-2011 69

Name and address of person who completed cause of death (Item 23a) (T

NOV 0 7

Charles ST, BATTMAP, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Month Day ZOIZ Hamid Ahmad Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min 217-74-1279 Director 80 1 X M 2 D F 02/16/1932 Pakista_n Usual Residence of Deced "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9923 Gable Ridge Terrace Apt I 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8yrs. Diesel Mechanic Mechanic Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abdul Majeed Mirza Amtul Quraish-Khan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Farhan Qureshy (Son) 625 Linslade Mews Gaithersburg, Md. 20878. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake_View 11/03/2012 Sykesville,Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death massive cerebrovascular accident Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner dus. , hasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 this certificate has been signed by the attending ral director, page 2 should be detached for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Thunknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ခ 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 Hnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, IN D M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drist, Rockwill, Huasheng LU, MD center 9901 Mediat 31. Date filed (Month, Day, Year) /32. Registrar's Signature 7 Registrar

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